WEISSGLASS PSYCHOLOGICAL SERVICES PLLC

Intake Form

Client Name: _____ Gender: _____

D.O.B: _____

Complete Address: _____

Home Telephone #: _____ Work Telephone #: _____

Email: _____ Cell Telephone #: _____

Employment Status: _____ Marital Status: _____

Emergency Contact: _____ Relation to Patient: _____

Complete Address: _____

Home Telephone#: _____ Work Telephone: #: _____

Cell Telephone #: _____ Email: _____

Emergency Contact: _____ Relation to Patient: _____

Complete Address: _____

Home Telephone#: _____ Work Telephone: #: _____

Cell Telephone #: _____ Email: _____

1409 N Highland Ave, Ste J Atlanta, GA 30306
Office: (404) 913-4824
www.weissglasspsych.com

WEISSGLASS
PSYCHOLOGICAL SERVICES
PLLC

Intake Form

Primary Care: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Referred By: _____

Reason for seeking services: _____

_____

How long have you been experiencing these problems?: _____

_____

Current Medications (include dosage and frequency): _____

_____

Past Diagnoses: _____

_____

Previous Outpatient Therapy: _____

_____

Previous Inpatient Treatment: _____

_____

What are your goals in seeking services? _____

_____

1409 N Highland Ave, Ste J Atlanta, GA 30306
Office: (404) 913-4824
www.weissglasspsych.com

Signature on File

(Please initial each applicable line and sign at bottom of page)

____ I understand that I am responsible for my bill.

____ I authorize Dr. Cortney Weissglass, (Weissglass Psychological Services, LLC) to charge my card on file pursuant to the credit card authorization policy.

____ I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient/Guardian Name Date

_____ _____

Signature Date

*Relationship if not patient _____

* The signature of a parent or legal guardian is required if the patient is under 18 years of age or legally incompetent.

WEISSGLASS PSYCHOLOGICAL SERVICES PLLC

Statement of Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, we only release information about your treatment to others if you sign a written authorization form. There are other situations that require that you provide written, advance consent. Your signature on this contract provides consent for those activities, as follows:

- We occasionally consult with other health and mental health professionals about a case. The other professionals are legally bound to keep the information confidential.
- If we believe that a patient presents an imminent danger to his/her health or safety, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information **without** your consent:

- If you are involved in a court proceeding and a request is made for information concerning the services that we provided you, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization, *or* a court order.
- If a government agency requests information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

There are some situations in which we are legally obligated to divulge information about your case, when we believe it is necessary to protect others from harm. In these cases, we may have to reveal some information about a client's treatment.

- If we have cause to suspect that a child under 18 is abused or neglected, the law requires that we file a report with the State Central Register of Child Abuse and Maltreatment and the local department of social services (LDSS). If we have reasonable cause to believe that a disabled adult is need of protective services, we are required to file a report with the LDSS Adult Protective Services (APS).
- If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim (if identifiable), and/or calling the police.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to what is necessary.

I understand the above policies. I consent to the provision of services.

_____ _____

Signature of Patient Date Office Staff or Doctor's Signature Date

_____

Signature of Parent/Guardian Date

1409 N Highland Ave, Ste J Atlanta, GA 30306
Office: (404) 913-4824
www.weissglasspsych.com

Policies & Procedures

This contract contains information about our services and the Health Insurance Portability and Accountability Act (HIPAA). HIPPA is a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A Notice of Privacy Practices (NPP) is attached to this contract and explains HIPAA in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information. Signing this agreement also represents an agreement between us. You may revoke this contract in writing at any time, which will be binding on us unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

APPOINTMENTS

Your appointment represents time reserved for you. As schedule permits, we will work out the most convenient time for you for these appointments. We reserve the right to charge a $225 fee for broken appointments and cancellations made less than 48 hours in advance of your appointment time. Please help us serve you better by keeping scheduled appointments. We have 24-hour voicemail service for your convenience. Simply call (404) 913-4824 and leave a voice message or email us at info@weissglasspsych.com. We also reserve the right to reschedule your appointment if you arrive late, dependent upon the schedule that day. Evaluation appointments will require a $250 deposit (toward the total evaluation fee) in order to secure your appointment time.

PAYMENT OF FEES

Payment is to be made in full at time of service. We accept cash, check, or credit card. Unpaid balances older than 60 days may be subject to an interest charge of 1.5% per month (15% annually). Payments are non-refundable. You will be liable for all costs if your account defaults and requires the use of a collection agency. In addition, you will be liable for all other costs incurred in their service including, but not limited to, corporation fees, attorney's fees, and all court related expenses. Services may be interrupted until payment is made.

INSURANCE/THIRD PARTY/MANAGED CARE

We highly recommend that you verify your insurance benefits prior to beginning services. As a courtesy to you, we will provide you with a receipt for all services to be submitted to your insurance company. Your insurance policy is a contract between you and your insurance carrier; we are not the party to contact. It is your responsibility to obtain authorization for the initial visit.

CONTACTING YOUR THERAPIST

In the event that Dr. Weissglass is unavailable to take your call, you may leave a voice message or send an email message and she will make every effort to return your message on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you will be available.

AUTHORIZED CONTACT METHODS

Please initial next to the methods of contact you authorize Dr. Weissglass (Weissglass Psychological Services, LLC) to leave you messages: ____ Email ____Cell Phone ____ Home Phone ____ Work Phone

PROFESSIONAL RECORDS

The laws and standards of the helping profession require that we keep PHI about you in your Medical Record. Except in circumstances that involve danger to yourself and/or others, or the record makes reference to another person and we believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Medical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence or have them forwarded to another professional so you can discuss the contents. If we refuse your request for access to records you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Medical Records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this contract, the attached NPP form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

READ CAREFULLY AND COMPLETE

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____ _____

Signature of Patient or Responsible Party Date Office Staff or Doctor's Signature Date

Please feel free to direct any questions to Dr. Weissglass. Your understanding of this contract is important to me and I am happy to discuss any or all of these conditions with you at any time. I look forward to serving you and your family.

WEISSGLASS PSYCHOLOGICAL SERVICES PLLC

Fees for Services

Please refer to this fee schedule as my fees vary depending on the service being provided. I reserve the right to change fees at any time; however, you will be notified before such a change occurs. Please be aware that you may be charged for other services including report writing, telephone conversations or email writing/conversations lasting longer than 15 minutes, consulting with other professionals with your permission, emergency, after-hour, face-to-face, or phone consultation, preparation of records or treatment summaries, and the time spent performing any other service you may request.

Intake Appointment (Therapy and Evaluations)	**$300.00/session**
Therapy Session (45 minutes)	**$225.00/session**
Group Therapy Session	**$105.00/session**
Psychoeducational Evaluation	**$3,100.00 +**
Psychological Evaluation	**$3,500.00 +**
Evaluation Deposit to secure appointment	**$250.00**
Phone/Email Consultation per 15 minute	**$60.00/interval**
Consultation	**$250.00/hour**
Legal Preparation, Consultation & Testimony	**$600.00/hour**
Returned Check Fee	**$40.00**
Cancelled/Missed Appointment Fees	
Less than 48 hour notice	**Fee for appointment or deposit**

Updated 06/21

1409 N Highland Ave, Ste J Atlanta, GA 30306
Office: (404) 913-4824
www.weissglasspsych.com

WEISSGLASS PSYCHOLOGICAL SERVICES PLLC

Notice of Policies and Practices (NPP) to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW IT CAREFULLY.***

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- **"*PHI*"** refers to information in your health record that could identify you.
- ***"Treatment, Payment and Health Care Operations"***
  - ***Treatment*** is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - ***Payment*** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ***Health Care Operations*** are activities that relate to the performance and operation of our practice. Examples of health care operations include: quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- **"*Use*"** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"*Disclosure*"** applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An ***"authorization"*** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. ***"Psychotherapy notes"*** are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that **(1)** We have relied on that authorization; or **(2)** if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If you give us information that leads us to suspect child abuse, neglect, or death due to maltreatment, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, we must do so.
- **Adult and Domestic Abuse:** If information you give us gives us reasonable cause to believe that a disabled adult is in need of protective services, we must report this to the Director of Social Services.
- **Health Oversight:** The Georgia Psychology Board has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** We may disclose your confidential information to protect you or others from a serious threat of harm by you.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post such changes in the office and will provide paper copies of changes upon request.

V. Complaints

- If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please contact Dr. Cortney Weissglass at **(404) 913-4824** or send a written complaint to **1409 N Highland Ave, Ste J Atlanta, GA 30306.**
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go initially into effect on April 30, 2014. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting new information in the office waiting room. Hard (paper) copies will be available upon request.

(rev. 3/16)