BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC.
9757 BLUE RIDGE DRIVE
BLUE RIDGE, GA 30513
OFFICE 706-455-2490 OR 706-455-6803 FAX 706-946-6574

☐ KYLE RAQUE PSY. D.,	☐ DEBBIE MIKOS M.S., LPC., CPSCS.
☐ FRANK BATKINS PH. D.,ABPP.,	☐ SUSAN KAUFFMAN M.A., L.P.C.
☐ RACHEL SIEGEL L.C.S.W.	☐ MEGAN HOLCOMB PH.D
☐ RON SEIFERT PH.D	

ADULT

CLIENT_____ **DATE** _____

AGE _____ **SEX** _____ **DOB** _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

INSURANCE _____, **POLICY NUMBER**_____

NAME ON INSURANCE POLICY_____**DOB**_____

PLEASE LIST ANY PHONE NUMBERS WHERE YOU MAY BE REACHED:

CELL:_____ **HOME:**_____

WORK _____ **EMERGENCY** _____

WHAT HAS LED YOU TO SEEK PSYCHOLOGICAL ASSISTANCE AT THIS TIME: _____

_____

PRIMARY CARE PHYSICIAN _____

I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE ON MY BEHALF TO BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC FOR ANY SERVICES PROVIDED. I AUTHORIZE BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC. TO RELEASE ANY MEDICAL INFORMATION TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS IN ORDER TO DETERMINE THESE BENEFITS.

SIGNATURE _____ **DATE** _____

***NOTE: DUE TO THE COVID-19 SITUATION OUR OFFICE IS OPERATING REMOTELY. NO CLIENTS WILL BE SEEN IN THE OFFICE. PLEASE DO NOT COME TO THE OFFICE. INSTEAD, OUR THERAPIST WILL STILL BE PROVIDING YOUR CARE VIE PHONE OR VIDEO. YOU MAY FAX PAPERWORK TO US AT 7069466574 OR SEND IT TO US VIA EMAIL TO** secure@blueridgepsychological.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name_____ Date of Birth _____

I, _____ hereby authorize **BLUE RIDGE PSYCHOLOGICAL SERVICES** to exchange specific health information from the records of the above name client to:-

_____

_____

_____

For the specific purpose(s) Treament Coordination

_____

I understand that this authorization will expire on the following date event or condition: Aftter 1 year

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the bottom of this page. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentially Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

_____(initials required for this section)_ I understand that by initialing this section, if my record contains information relating to HIV infection, AIDS, or AIDS-related condition. By not initialing this section, such information may not be released. Release of this information occurs in accordance with NCGS130A-143

_____(initials required for this section) I understand that by initialing this section, if my record contains information relating to alcohol abuse, drug abuse, or genetic testing this disclosure will include that information. By not initialing this section, such information may not be released. Release of this information or\occurs in accordance with 42 CFR Part 2

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment of services, or my eligibility for benefits; however, if a service is requested by a non-treatment, provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given, I further understand that I may request a copy of this signed authorization.

_____ _____ _____

_ Signature of client Date Witness if required

BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC
9757 BLUE RIDGE DRIVE,
BLUE RIDGE, GA 30513

PAYMENT POLICY: PSY.D, AND PH.D.

THE FOLLOWING PAYMENT POLICIES ARE IN EFFECT AS OF MAY 1, 2009

1. FEES	INITIAL SESSION (INTAKE INTERVIEW AND ASSESSMENT)	$180.00
	INDIVIDUAL THERAPY (45 -50 MINUTES IN LENGTH)	$150.00
	INDIVIDUAL THERAPY (75-80 MINUTES IN LENGTH)	$180.00
	FAMILY/COUPLES THERAPY (2 HOUR APPOINTMENT)	$350.00
	FAMILY/COUPLES THERAPY (90 MINUTES)	$200.00
	COURT EXPERT WITNESS (PER HOUR)	$200.00

PAYMENT POLICY: L.P.C., L.C.S.W.

THE FOLLOWING PAYMENT POLICIES ARE IN EFFECT AS OF MAY 1, 2009

1. FEES	INITIAL SESSION (INTAKE INTERVIEW AND ASSESSMENT)	$150.00
	INDIVIDUAL THERAPY (45-50 MINUTES IN LENGTH)	$125.00
	INDIVIDUAL THERAPY (75 – ERAMINUTES IN LENGTH	$150.00
	FAMILY/COUPLES THERAPY (45-50 MINUTES IN LENGTH)	$125.00
	FAMILY/COUPLES THERAPY (75-80MINUTES IN LENGTH)	$150.00
	COURT EXPERT WITNESS (PER HOUR)	$200.00

2. CLIENT ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR PAYMENT ON ALL SERVICES RENDERED, INCLUDING FEES NOT PAID BY INSURANCE COMPANY.

3. CANCELLATIONS NOT MADE WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT WILL RESULT IN A NO SHOW/LATE CANCELLATION AND A FEE WILL BE DETERMINED BY YOUR PROVIDER.

BY SIGNING, I CERTIFY THAT I HAVE READ THE ABOVE AGREEMENT, THAT I HERE TO IT. UNDERSTAND IT, AND THAT I WILL ADHERE TO IT.

I HEREBY ACKNOWLEDGE THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. FAILURE TO DO SO MAY RESULT IN TERMINATION FROM THE PRACTICE.

IF YOU HAVE A CO-PAY PLEASE TAKE CARE OF IT PRIOR TO YOUR APPOINTMENT TODAY.

SIGNATURE: _____ DATE _____

BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC
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CONSENT OF NON-SECURE FORMS OF ELECTRONIC COMMUNICATION

ELECTRONIC COMMUNICATION, VIA EMAIL AND TEXT, BETWEEN YOU AND YOUR THERAPIST MAY NOT BE SECURE. BY SIGNING BELOW, YOU ARE ACKNOWLEDGING THAT YOU REALIZE THAT EMAIL AND TEXT COMMUNICATION DOES NOT PROVIDE A COMPLETELY SECURE MEANS OF COMMUNICATION. WHILE YOUR THERAPIST WILL TAKE REASONABLE EFFORTS TO PROTECT YOUR CONFIDENTIALITY, THERE IS SOME RISK THAT ANY PROTECTED HEALTH INFORMATION CONTAINED IN EMAIL OR TEXT MAY BE DISCLOSED TO OR INTERCEPTED BY UNAUTHORIZED THIRD PARTIES.

YOUR TREATMENT WILL NOT DEPEND ON YOU GIVING CONSENT. YOU ALSO HAVE THE RIGHT TO TERMINATE THIS AGREEMENT AT ANY TIME.

USE OF MORE SECURE COMMUNICATIONS, SUCH AS PHONE OR FAX, ARE ALWAYS AN ALTERNATIVE THAT ARE AVAILABLE TO YOU IF YOU ELECT TO NOT GIVE CONSENT TO THE FOLLOWING FORMS OF COMMUNICATION.

I GIVE PERMISSION FOR MY THERAPIST TO CONTACT ME USING NON-SECURE METHODS REGARDING REMINDERS, SCHEDULING, OR OTHER RELEVANT MATTERS, AND I UNDERSTAND THE RISKS INVOLVED:

TEXT COMMUNICATION	**YES ( )**	**NO ( )**
EMAIL COMMUNICATION	**YES ( )**	**NO ( )**

YOUR EMAIL

_____

_____ _____ _____

_____

CLIENT NAME

BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC
9757 BLUE RIDGE DRIVE,
BLUE RIDGE, GA 30513

CLIENTS RIGHTS AND INFORMATION

EFFECTIVE COMMUNICATION BETWEEN THE CLIENT AND THE THERAPIST IS AN IMPORTANT PART OF THE THERAPY PROCESS. THE FOLLOWING INFORMATION COVERS MANY OF THE QUESTIONS THAT MAY ARISE ABOUT THERAPY AND INCLUDES A LISTING OF THE CLIENT'S RIGHT AS AND THE THERAPIST'S OBLIGATIONS. ANY QUESTIONS YOU MAY HAVE THAT ARE NOT COVERED MAY BE BROUGHT TO THE ATTENTION OF YOUR THERAPIST.

CLIENTS SEEKING PSYCHOLOGICAL SERVICES HAVE THE RIGHT TO KNOW THE FOLLOWING:

1. **INFORMATION ABOUT THE AVAILABILITY OF THE THERAPIST. CLIENTS ARE INVITED TO INQUIRE ABOUT; WHEN THE THERAPIST IS AVAILABLE AND WHERE TO CALL DURING OFF HOURS IN CASE OF EMERGENCY.**

2. INFORMATION ABOUT THE STRUCTURE OF THE THERAPEUTIC RELATIONSHIP. CLIENTS ARE INVITED TO INQUIRE ABOUT:

- **THE MANNER IN WHICH THE THERAPIST CONDUCTS SESSIONS CONCERNING INTAKE, TREATMENT AND TERMINATION. CLIENTS MAY TAKE ACTIVE ART IN THEIR THERAPEUTIC PROCESS BY ASKING QUESTIONS ABOUT ISSUES RELEVANT TO THERAPY, SPECIFYING THERAPEUTIC GOALS AND RENEGOTIATING GOALS WHEN NECESSARY.**
- **THE PERSPECTIVE(S) THE THERAPIST TYPICALLY UTILIZES TO STRUCTURE INTERVENTION AND ALTERNATIVE METHODS OF TREATMENT.**
- **THE PURPOSE OF THE RISKS INVOLVED IN PSYCHOLOGICAL INTERVENTION. CLIENTS MAY REFUSE ANY INTERVENTION OR TREATMENT STRATEGY.**
- **THE ANTICIPATED LENGTH AND FREQUENCY OF TREATMENT AND LIMITATIONS THAT MAY ARISE DUE TO DIFFICULTIES IN FINANCING.**
- **THE LIBERTY OF CLIENTS TO DISCUSS ANY ASPECT OF THEIR THERAPY WITH OTHERS OUTSIDE THE THERAPY SITUATION, INCLUDING CONSULTATION WITH ANOTHER THERAPIST.**

3. INFORMATION ABOUT THE FEES AND BILLING ARRANGEMENTS. CLIENTS ARE INVITED TO INQUIRE ABOUT:

- THE AMOUNT OF THE FEE
- THE TIME FRAME FOR PAYMENT.
- THE METHOD OF PAYMENT INCLUDING FEE FOR SERVICE AND INSURANCE REIMBURSEMENT.
- THE ACCESS TO BILLING STATEMENTS.
- THE BILLING FOR MISSED APPOINTMENTS AND LATE CANCELLATIONS

CLIENT SIGNATURE _____ DATE _____

_____
CLIENT NAME

BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC
9757 BLUE RIDGE DRIVE,
BLUE RIDGE, GA 30513

GEORGIA NOTICE FORM

NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES 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

I MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI), FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PURPOSES WITH YOUR CONSENT. TO HELP WITH 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 I PROVIDE, COORDINATE OR MANAGE YOUR HEALTH CARE AND OTHER SERVICES RELATED TO YOUR HEALTH CARE. AN EXAMPLE OF TREATMENT WOULD BE WHEN I CONSULT WITH ANOTHER HEALTH CARE PROVIDER, SUCH AS YOUR FAMILY PHYSICIAN OR ANOTHER PSYCHOLOGIST.

PAYMENT IS WHEN I OBTAIN REIMBURSEMENT FOR YOUR HEALTH CARE. EXAMPLES OF PAYMENT ARE WHEN I DISCLOSE YOUR PHI TO YOUR HEALTH INSURER TO OBTAIN REIMBURSEMENT FOR YOUR HEALTH CARE OR DETERMINE ELIGIBILITY OR COVERAGE

HEALTH CARE OPERATIONS ARE ACTIVITIES THAT RELATE TO THE PERFORMANCE AND OPERATION OF MY PRACTICE. EXAMPLES OF HEALTH CARE OPERATIONS ARE QUALITY ASSESSMENTS AND IMPROVEMENT ACTIVATES BUSINESS RELATED MATTERS SUCH AS AUDITS AND ADMINISTRATIVE SERVICES, AND CASE MANAGEMENT AND CARE COORDINATION.

"USE" APPLIES ONLY TO ACTIVITIES WITHIN MY (OFFICE, CLINIC, PRACTICE GROUP, ETC.) SUCH AS SHARING, EMPLOYING APPLYING, UTILIZING AND ANALYZING INFORMATION THAT IDENTIFIES YOU .

"DISCLOSURE" APPLIES TO ACTIVITIES OUTSIDE MY (OFFICE, CLINIC, PRACTICE GROUP, ETC) SUCH AS RELEASING TRANSFERRING OR PROVIDING ACCESS TO THE INFORMATION ABOUT YOU TO OTHER PARTIES.

_____ I, THE RESPONSIBLE PARTY(LEGAL GUARDIAN) DO HEREBY GRANT PERMISSION FOR BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC TO NOTIFY EMERGENCY SERVICES, INCLUDING 911, IN THE EVENT OF THE OCCURRENCE OF A MEDICAL EMERGENCY, AND I DO HEREBY CONSENT TO THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION THAT IS NECESSARY FOR EMERGENCY SERVICES PERSONNEL TO PROVIDE CARE TO MYSELF OR MY CHILD.

CLIENTS SIGNATURE: _____/DATE_____

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GEORGIA NOTICE FORM

NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

I MAY USE OR DISC LOSE PHI FOR PURPOSES OUTSIDE OF TREATMENT, PAYMENT, OR 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 I AM ASKED FOR INFORMATION FOR PURPOSES OUTSIDE OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, I WILL OBTAIN AN AUTHORIZATION FROM YOU BEFORE RELEASING THIS INFORMATION. I WILL ALSO NEED TO OBTAIN AN AUTHORIZATION BEFORE RELEASING THIS INFORMATION. I WILL ALSO NEED TO OBTAIN AN AUTHORIZATION BEFORE RELEASING YOUR PSYCHOTHERAPY NOTES. "PSYCHOTHERAPY NOTES" ARE NOTES I HAVE MADE ABOUT OUR CONVERSATION DURING A PRIVATE, GROUP, JOINT, OR FAMILY COUNSELING SESSION, WHICH I HAVE KEPT SEPARATE FROM THE REST OF YOUR MEDICAL RECORD. THESE NOTES ARE GIVEN A GREAT DEGREE OF PROTECTION THAN PHI.

YOU MAY REVOKE ALL SUCH AUTHORIZATIONS) OF PSYCHOTHERAPY NOTES) AT ANY TIME, PROVIDE EACH REVOCATION IS IN WRITING. YOU MAY NOT REVOKE AN AUTHORIZATION TO THE EXTENT THAT (1) I HAVE RELIED ON THAT AUTHORIZATION: OR (2) IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE, LAW PROVIDES THE INSURER THE RIGHT TO CONTEST THE CLAIM UNDER THE POLICY.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION I MAY USE OR DISCLOSE PHI WITHOUT YOUR CONSENT OR AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES:

- CHILD ABUSE-IF I HAVE REASONABLE CAUSE TO BELIEVE THAT A CHILD HAS BEEN ABUSED, I MUST REPORT THAT BELIEF TO THE APPROPRIATE AUTHORITY.
- ADULT AND DOMESTIC ABUSE –IF I HAVE REASONABLE CAUSE TO BELIEVE THAT A DISABLED ADULT OR ELDERLY PERSON HAS HAD A PHYSICAL INJURY OR INJURIES INFLECTED UPON SUCH DISABLED ADULT OR ELDERLY PERSON, OTHER THAN BY ACCIDENTAL MEANS, OR HAS BEEN NEGLECTED OR EXPLOITED, I MUST REPORT THAT BELIEF TO THE APPROPRIATE AUTHORITY
- HEALTH OVERSIGHT ACTIVATES-IF I AM THE SUBJECT OF AN INQUIRY BY THE GEORGIA BOARD OF PSYCHOLOGICAL EXAMINERS, I MAY BE REQUIRED TO DISCLOSE PROTECTED HEALTH INFORMATION REGARDING YOU IN PROCEEDINGS BEFORE THE BOARD.
- JUDICIAL AND ADMINISTRATIVE PROCEEDINGS-IF YOU ARE INVOLVED IN A COURT PROCEEDING AND A REQUEST IS MADE ABOUT THE PROFESSIONAL SERVICES I PROVIDED YOU OR THE RECORDS THEREOF, SUCH INFORMATION IS PRIVILEGED UNDER
- SERIOUS THREAT TO HEALTH OF SAFETY- FF I DETERMINE, OR PURSUANT TO THE STANDARDS OF MY PROFESSION SHOULD DETERMINE, THAT YOU PRESENT A SERIOUS DANGER OF VIOLENCE TO YOURSELF OR ANOTHER, I MAY DISCLOSE INFORMATION IN ORDER TO PROVIDE PROTECTION AGAINST SUCH DANGER FOR YOU OR THE INTENDED VICTIM.
- WORKER'S COMPENSATION- MPMAY DISCLOSE PROTECTED HEALTH INFORMATION REGARDING YOU AS AUTHORIZED BY AND TO THE EXTENT NECESSARY TO COMPLY WITH LAWS RELATING TO WORKER'S COMPENSATION OR OTHER SIMILAR PROGRAMS, ESTABLISHED BY LAW, THAT PROVIDE BENEFITS FOR WORK-RELATED INJURIES OR ILLNESS WITHOUT REGARD TO FAULT.

IV Patient's Rights and Psychologist's Duties

- Right to Request Restrictions- Sou have the right to request restrictions on certain uses and disclosures of protected health information, However, I am not required to agree to a restriction YOU REQUEST.
- Right to Receive Confidential Communications by Alternative Means and at Locations- Cou 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. On your request, I will send your bills to another address.
- Right Inspect and Copy – Pou have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I 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. I may deny you request. On your request, I will discuss with you the details of the amendment process.
- Right to An Accounting- Cou generally have the right to receive an accounting of disclosures of PHO On your request, I will discuss with you the details of the accounting process.
- Right to Paper Copy- Pou have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- **I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.**
- **I reserve the right to change the privacy policies and practices described in the is notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.**
- **If I revise my p0olicies and procedures, I will notify you in writing by mail or in person..**

V. Questions and Complaints

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send you r written complaint.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services . The person listed about can provide you the appropriate address unpin your request. You have specific rights under the privacy rule. I will not retaliate against you for exercising your right to file.

VI. Effective Date, Restrictions, and Changes to Privacy Policy- This Notice will go into effect March 1, 2007

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revise notice in writing.

Your signature below indicates that you have read and agree to Georgia Notice Form and abide by its terms during our professional relationship.

Your signature also indicates that you have taken the Georgia Notice of Health Information Privacy Practices. This notice describes how Medial information about you may be used and disclosed and how you can get access to the information.

Signature _____ Date _____

BLUE RIDGE PSYCHOLOGICAL SERVICES, LLC

CLIENT NAME: _____

CLIENT DOB_____

TREATMENT PLAN

AT THE END OF YOUR MEETING TODAY, YOUR THERAPIST WILL HELP YOU TO FURTHER DEVELOP YOUR TREATMENT PLAN IN ORDER TO REACH YOUR GOALS. (TO BE COMPLETED BY YOU AND YOUR THERAPIST AT THE END OF THE FIRST SESSION OR THE BEGINNING OF YOUR SECOND SESSION, NO LATER THAN 15 BUSINESS DAYS AFTER YOUR FIRST MEETING WITH YOUR THERAPIST)

PLEASE TELL US WHAT YOU WOULD LIKE TO WORK ON IN THERAPY. WHAT ARE YOUR TREATMENT GOALS>?

MY GOALS ARE: (WHAT WOULD "BETTER" LOOK LIKE? HOW WOULD YOU KNOW THAT THERAPY HAD "WORKED"? WHAT WOULD BE DIFFERENT OR WHAT WOULD CHANGE?

1.

2.

3.