Blue Ridge Pyschological Services
9757 Blue Ridge Drive
Blue Ridge, GA 30513

☐ I have received, read and understand my HIPAA rights and responsibilities

☐ I have been offered and declined a copy of my HIPAA rights and responsibilities

Signature **Date**

Witness **Date**

Blue Ridge Psychological Services, LLC
Intake Paperwork

9757 Blue Ridge Drive
Blue Ridge, Georgia 30513
Office 706-455-2490 or 706-455-6803
Fax 706-946-6574
Email: secure@blueridgepsychological.com

- Kyle Raque Psy.D.
- Debbie Mikos M.S. L.P.C. CFMHE CCCE C.P.C.S.
- J. Frank Batkins Ph.D.
- Brian Johnson Ph.D.
- Terry Kinton Ph.D.
- Hope Cross M.A. L.A.P.C.
- Cliff Owl, Psy.D.
- Kyva Bryant, Psy.D.

Client Name:_____ Date:_____

Client Age:_____ Client DOB: _____ Client Gender:_____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Home Address (if different from above):

Street:_____

City:_____ State:_____ Zip:_____

If Client is Minor:

Name of Parent/Legal Guardian: _____

Relationship to Client: _____

Address (if Different than Client): _____

City: _____ State:_____ Zip: _____

Contact Information:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact: _____

Phone: _____ Relationship to Client: _____

Primary Care Physician: _____

Phone Number: _____

How did you find out about us?: _____

What has lead you to seek psychological assistance at this time?:

Have you had previous counseling?:_____ Dates: _____

Name of Counselor(s):_____

_____

Consent to Treatment

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. It is not unusual to experience periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

I, _____ , am voluntarily seeking counseling at Blue Ridge Psychological Services, LLC (BRPS). I understand that I have rights and responsibilities regarding my participation in counseling, including the right to discontinue counseling at any time. I acknowledge that I have read, understand, and agree to the policies and procedures involved in counseling at BRPS I also acknowledge that I have been given a copy of the HIP AA/Privacy Practices implemented at BRPS. I understand that BRPS may offer existing clients emergency coverage through our on-call therapist. I understand that I may call and leave a message on the main office phone for my therapist to contact me. That message will be routed to your therapist and/or the on-call therapist who will call you back as soon as possible. However, if they are not able to call you back immediately, I understand that in a life-threatening emergency, I should call 911 or go to the nearest Emergency Room or I can call the National Suicide Prevention Hotline at 800 -273-8255, or participate in an on-line chat with a crisis counselor at https://suicidepreventionlifeline.org/chat/.
I agree that I will not hold BRPS or its agents liable in any way for my safety.
I understand the terms described above and agree to counseling services at Blue Ridge Psychological Services.

_____

Client Signature Date

_____

Signature of Party Legal Responsible for Client Date

Consent of Non-Secure Forms of Electronic Communication

Electronic communication between you and your therapist, via email and/or text, may not be secure. While your therapist will take reasonable precautions to protect your confidentiality, the risk remains that any protected health information contained in email or text may be disclosed to or intercepted by unauthorized third parties.

Use of more secure communications, such as phone or fax, are always an available alternative if you elect not to give consent to email or text.

Your treatment will not be dependent on you giving consent. You also have the right to terminate this agreement at any time.

I give permission for my therapist and Blue Ridge Psychological Services staff to contact me using the non-secure methods checked below, including reminders, scheduling, or other relevant matters, and I understand the risk involved.

☐ **Designated Email Communication: _____**

☐ **Designated Text Communication: _____**

(IF Email/Text is not designated, communications will go to those on file)

_____

Client Signature Date

_____

Signature of Party Legal Responsible for Client Date

Consent for Release in Case of Emergency

In the event that I or my dependent might have a medical emergency at our facility or during a virtual meeting with my therapist, I consent to the release of all necessary information in order to provide emergency care or contact emergency services on my or my child's behalf.

I give permission for Blue Ridge Psychological Services staff or agents to release any information that they believe might help aid in my or my dependent's emergency medical care. By signing below, I consent to this release in the event of an emergency.

_____

Signature of Client or Legal Guardian

Date

Blue Ridge Psychological Services
9757 Blue Ridge Drive
Blue Ridge, Georgia 30513

Fee Schedule

Payment Policy for Psy.D and Ph.D.

• Initial Session (Intake Interview and Assessment)	**$210.00**
• Individual Therapy (45 - 60 minutes)	**$180.00**
• Individual Therapy (60 - 80 minutes)	**$210.00**
• Family/Couples Therapy (90 minutes)	**$230.00**
• Family/Couples Therapy (120 minutes)	**$350.00**
• Court Testimony Fees (per hour)	**$300.00**

Payment Policy for L.P.C. and L.C.S.W.

• Initial Session (Intake Interview and Assessment)	**$180.00**
• Individual Therapy (45 - 60 minutes)	**$140.00**
• Individual Therapy (60 - 80 minutes)	**$180.00**
• Family/Couples Therapy (90 minutes)	**$180.00**
• Family/Couples Therapy (120 minutes)	**$300.00**
• Court Testimony Fees (per hour)	**$250.00**

Insurance Information

If you wish for us to file insurance, please complete the information below so that we can verify your coverage prior to your appointment.

Also, please bring your insurance card with you to your first appointment. Thanks!

Name of Insurance Policy: _____

Name of Policy Holder: _____ DOB: _____

Member / Subscription ID Number: _____

Financial Policy and Release of Information

Payment of services is expected at the time of services. It is important that you read and understand the fee schedule provide and the financial policy/ release of information described below. Please feel free to ask if you have any questions regarding these policies. Understanding our financial policies is important to our relationship.

I, _____ , understand the fee schedule and accept full financial responsibility for payment of all services rendered, including copays, co-insurance amounts, deductibles and any amount not paid by my insurance carrier.

I further understand that payment is expected at the time that services are rendered. Blue Ridge Psychological Services files insurances as a courtesy and reserves the right to not file insurance. I acknowledge that uncollected balances may be turned over to collections and/or to the court.

I authorize Blue Ridge Psychological Services, LLC., to release limited information required for the purposes of billing for my treatment to my insurance company(s) or government agency(s) providing my benefits, enabling them to process preauthorization and/or claims on my behalf. I understand that I may request the release of additional clinical or treatment information by completing the appropriate release of information form. I also authorize my insurance carrier(s) to make payment directly to Blue Ridge Psychological Series, LLC., for all services rendered. I understand that I will be charged an additional fee of $35.00 for any check or draft dishonored by our financial institution.

_____

Client Signature Date

_____

Signature of Party Financially Responsible for Client Date

_____

Signature of Party Legal Responsible for Client Date

Cancellation Policy

Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so that we can offer that time to someone else. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments up to the rate of your full payment amount for that appointment. This will be billed to your account. We may require prepayment in order to schedule a subsequent appointment.

Please note that a “no show” is an appointment that you fail to cancel and fail to attend. Two “no shows” may result in you being taken off the schedule until you call the office to reschedule and prepay your fees, at the discretion of the provider.

Confidentiality

All interactions with Blue Ridge Psychological Services, LLC., including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. Information obtained from minors is not generally shared with parents without permission. You may request in writing that the staff at Blue Ridge Psychological Services, LLC., release specific information about your treatment records to persons you designate. The staff will provide Release of Information (ROI) forms available for you to sign as needed.

Exceptions to confidentiality:

- The staff at Blue Ridge Psychological Services works as a team. Your therapist may consult with other staff members to provide the best possible care. These conditions are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self or others, a therapist is ethically required to report this information to the authorities responsible for ensuring safety.
- Georgia state law requires that therapist who learn of, or strongly suspect, physical, mental, or sexual abuse or neglect of any person must report this information to the Department of Family and Children Services.
- A court order, signed by a judge, may require your therapist and/or Blue Ridge Psychological Services, LLC., to release information contained in records and/or require a therapist to testify in a court hearing.

Client Rights and Information

Effective communication between you, the client, and your 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 your rights as the client and your therapist's obligations. Any questions you may have that are not covered here 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 an emergency.
2) Information about the structure of the therapeutic relationship. Clients are invited to inquire about:
    a) The manner in which the therapist conducts sessions concerning intake, treatment, and termination. Clients may take an active part in their therapeutic process by asking questions about issues relevant to therapy, specifying therapeutic goals and renegotiating goals when necessary.
    b) The perspective(s) the therapist typically utilizes to structure interventions and alternative methods of treatment.
    c) The purpose of the risks involved in psychological intervention. Clients may refuse any intervention or treatment strategy.
    d) The anticipated length and frequency of treatment including any limitations that may arise due to unforeseen events and difficulties in financing.
    e) The liberty of clients to discuss any aspect of their therapy with others outside the therapy sessions, including consultation with another therapist.
3) Information about the fees and billing arrangements. Clients are invited to inquire about:
    a) The amount of the fee.
    b) The time frame for payment.
    c) The method of payment, including fee for service and insurance reimbursement.
    d) Access to billing statements.
    e) Billing for missed appointments and late cancellations.

I acknowledge that I have read, understand, and agree to the policies and procedures described in this intake package**, including the consent to treatment, the consent to non-secure communication, the financial policy, the cancellation policy, the confidentiality statement including the exceptions to confidentiality, and the client's rights and information.**

I also acknowledge that I have been offered a copy of the HIP AA/Privacy Practices.

_____

Client Signature Date

_____

Signature of Party Legal Responsible for Client Date

HIPAA AUTHORIZATION FOR USE: OR DISCLOSURE OF HEALTH INFORMATION

This form ls for use when such authorization is required and compiles with the Health Insurance Portability and Accountability Act of 1996 (HIPM) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

My Authorization
I authorize the following using or disclosing party: Blue Ridge Psychological Services, LLC

To use or disclose the following health Information: (check one)

- ☐ All of my health Information
- ☐ My health Information relating to the following treatment or condition:

- ☐ My health Information covering the period from _____ (date) to _____
- ☐ Other

The above party may disclose this health Information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is: (check all that apply)

- ☐ At my request
- ☐ Other: _____

- ☐ On date: _____

- ☐ When the folllowing event occurs: _____

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization If Its purpose was to obtain insurance. In order to revoke this authorization, I must do so In writing and send It to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Information used or disclosed with my permission may be re disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment Is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____

Patient Signature Date

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor

Age: _____

☐ Patient is unable to sign

Reason:

_____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other

Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health** treatment. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

_____

Signature of Patient or Authorized Representative Date & Time

Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

_____

Signature of Patient or Authorized Representative Date & Time