

Jennifer M. Keith, Psy.D.
Psychoeducational/Psychological Assessment Agreement

Welcome to my practice. This document contains important information about my professional services and business policies with regard to assessment. Please read it carefully and let me know if you have any questions. Please acknowledge your understanding of this policy by signing at the end of this form.

Psychological/Psychoeducational Assessment: Psychological or Psychoeducational Assessment varies depending on the reason for referral. In all cases, the assessment process will include a battery of psychological measures as well as a clinical interview. Depending on the purpose of the evaluation, a battery of tests may include measures that assess cognitive abilities, achievement, memory, attention, and/or emotional and psychological well being. The number of tests and the length of the evaluation are dependent upon the reason for referral. The measures are administered by me and will likely be a combination of interactive and questionnaire type tests. The selected measures are widely used tests that have been shown to have good reliability and validity with regard to the reason for the evaluation. In addition, the tests are also selected for appropriateness with regard to age and educational attainment.

Professional Fees: My hourly fee is \$150.00 per hour for assessment sessions. This includes report writing, feedback sessions, and any additional feedback provided to a third party. Some insurance companies will provide reimbursement for certain testing procedures related to psychological testing. Most insurance companies will not provide reimbursement for educational testing. It is the responsibility of the patient or his/her parent or guardian to provide payment for testing services not covered by the insurance carrier. If you choose to use insurance, a pre-authorization is usually required. It is very common for insurance companies to pay differently than what they quoted you at the time of the first visit or deny coverage at a later date. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Any balances unpaid after 60 days are subject to a 1.5 % per month finance charge. Payment in full is expected at the time of service. Please inform me if there are exceptional circumstances prior to the first session.

Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. **Appointments not canceled with at least 24 hours notice will be billed at the usual fee of \$150.00 per reserved hour. Monday appointments must be canceled by 12:00 noon the Friday before to avoid charges.** It is important to note that insurance companies do not reimburse for missed or late canceled sessions, so the full \$150.00 fee will be your responsibility.

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. In most situations, I can only release information about your treatment to others (third party) if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to self, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child 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 first.

Agreement: 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 Signature _____
Date

Parent or Guardian Signature of minor _____
Date

Parent or Guardian Signature of Minor _____
(Both parents must sign if joint custody)

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

Jennifer M. Keith, Psy.D.
Psychotherapy Services Agreement

Welcome to my practice. The following document contains important information about my professional business policies with regard to psychotherapy. 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.

Psychotherapy Sessions: Our first few sessions will involve an evaluation of your needs. During this time, we can both decide if I am the best person to provide the services you need and formulate a treatment plan. If you decide to continue with therapy, we will schedule appointments at a mutually agreeable time. Sessions are typically 45-50 minutes in duration and are scheduled once per week in the beginning of the therapy process. The frequency of the sessions will depend on your individual needs.

Professional Fees: The fee for the initial diagnostic session is \$185.00. Remaining sessions are \$150.00 per session for individual therapy and \$165.00 for couples or family therapy. Charges for consultations outside the usual therapy hour (i.e. phone consults, court appearances, school observations, hospital visits, depositions, etc.) will be determined on an individual basis.

Payment Information: Payment is expected at the time services are rendered. I am an "in-network" provider for several insurance companies and will file insurance claims on your behalf. If you choose to use insurance, pre-authorization is usually required. It is your responsibility to contact your insurance company prior to our first session to determine your outpatient mental health benefits. Many insurance companies will reimburse a percentage of the fee for "out-of-network" providers. I will file out-of-network claims on your behalf. Until eligibility and benefits are determined, please plan on paying the full contracted amount. It is very common for insurance companies to pay differently than what they quoted you at the time of the first visit or deny coverage at a later date. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Any balances unpaid after 60 days are subject to a 1.5 % per month finance charge. Payment is expected at the end of each session.

Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. **Appointments not canceled with at least 24 hours notice will be billed at the usual fee of \$150.00. Monday appointments must be canceled by 12:00 noon the Friday before to avoid charges.** It is important to note that insurance companies do not reimburse for missed or late canceled sessions, so the full \$150.00 fee will be your responsibility.

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. In most situations, I can only release information about your treatment to others (third party) if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to self, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child 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 first.

Agreement: 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 Signature of minor

Date

Important Information for Insurance Patients

Insurance Patients: Please read the following information and sign the Agreement at the bottom of this page if you would like me to file insurance for you.

Health Insurance Coverage

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Despite our best efforts in determining your coverage, it is very common for insurance companies to pay differently than what they quoted you at the time of the first visit, deny coverage at a later date, or request a refund for funds previously dispersed. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services.

Authorization for Treatment

Many insurance plans require authorization before they provide reimbursement for mental health services. This authorization is typically required prior to or on the day of the first session. My office will do everything we can to acquire authorization on the first day of treatment, but, ultimately, it is the patient's responsibility to contact the insurance company for authorization. If the correct information is not provided at the first appointment, then this will likely delay the authorization process. Insurance companies rarely back-date authorizations, so the initial appointment and subsequent appointments may not be covered until authorization is obtained.

Insurance Reimbursement

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. **I am required to provide a clinical diagnosis for reimbursement.** Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will be in a database. I have no control over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information databank, which may affect your health insurance premiums, ability to acquire an individual insurance policy, or life insurance eligibility and premiums. I will provide you with a copy of any report I submit, if you request it. If you have any questions about this information, please let me know at the beginning of the first session. By signing this Agreement, you agree that I can provide requested information to your carrier.

Assignment of Benefits

I authorize Dr. Jennifer Keith to release any medical, diagnostic, or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Dr. Jennifer Keith 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 or denied coverage for any reason. I may receive a bill for services rendered if my insurance company does not reimburse as anticipated or requests a refund for previously paid services. I acknowledge responsibility for all fees incurred and accept responsibility for payment in full. 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 court and legal fees.

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

Patient Information:

NAME: _____
 First Middle Last

ADDRESS: _____
 Street City State Zip

PHONE: _____
 Home Work Cell

SOCIAL SECURITY #: _____ SEX: ___ Male ___ Female

MARITAL STATUS: S M D W DATE OF BIRTH: _____ AGE: _____

EMPLOYER: _____ POSITION: _____

Can a message be left at Home? ___ Yes ___ No Work? ___ Yes ___ No Cell? ___ Yes ___ No

REFERRED BY: _____ May I contact this person? ___ Yes ___ No

Have you been in therapy before? ___ Yes ___ No For your current problem? ___ Yes ___ No

If so, Where? _____ When? _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____
 Work Home Cell

Responsible Party/Spouse/Parent Information:

Name: _____ Date of Birth: _____ Phone: _____

Primary Insurance (if applicable):

Name of carrier: _____ Name of insured: _____

ID #: _____ Group #: _____ Phone #: _____

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? 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