

**Kim Oppenheimer, 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 \$160.00 per therapy hour and \$175.00 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 \$195.00. 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 an 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.
3. 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 \$160.00 or \$175.00. Missed appointments cannot be billed to the insurance company. You may leave a message with my answering service after hours and on weekends if you need to cancel an appointment.

**Statement of Confidentiality:** Confidentially 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

**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. Kim Oppenheimer to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Dr. Kim Oppenheimer 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

