

**Joni E. Prince, 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 \$150.00 per therapy hour and \$160.00 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 \$185.00. 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**. Visa and MasterCard are accepted for your convenience. An insurance receipt is available for your convenience in submitting your insurance claims. Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. If you are a member of a managed care company in which I participate, I will file insurance for you. 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 contracted amount.

\*\* The amount we collect is based on information we receive from your insurance company. However, we do not always receive accurate information. Therefore, please be aware that you may receive a bill for services after a session because there is often a delay from when we submit an insurance claim and when it is paid. Statements are sent after insurance has paid for a date of service.

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 \$150.00 or \$160.00. 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:** 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 him or her 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.

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

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## **Psychotherapy Services Agreement**

### **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

### **PROFESSIONAL FEES**

My hourly fee is \$185.00 for the initial session, \$150.00 per hour for individual or \$160.00 per hour for family sessions, thereafter. In addition to weekly appointments, I may charge this amount for other professional services you may need, such as report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$175.00 per hour for preparation and \$350.00 per hour for attendance at any legal proceeding.]

**Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so the full \$150.00 fee will be your responsibility.**

### **CONTACTING ME**

Due to my work schedule, I am often not immediately available by telephone. However, I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. When I will be unavailable for an extended time, the answering service can provide you with the name of a colleague to contact, if necessary.

### **LIMITS ON CONFIDENTIALITY**

What you and I discuss will remain between the two of us. There are a few exceptions, but the law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to you to consult other health and mental health professionals about a case. When I do this, I make every effort to avoid revealing the identity of my patient and the other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also have contracts with Medical Billing Associates. As required by HIPAA, I have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of this organization and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I 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 I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

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

## **PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, I keep two sets of professional records. This is my effort to protect your privacy. One set constitutes your Protected Health Information (PHI). It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person [or if information is supplied to me confidentially by others,] you or your legal representative may examine and/or receive a copy of your PHI, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I generally release Treatment Summary reports which include necessary information rather than each original document. In most situations, such as with the Treatment Summary, I am allowed to charge a copying fee and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record [and information supplied to me confidentially by others]. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies, with the exception of a court order signed by a judge. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

## **PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

## **MINORS & PARENTS**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

## **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

## **INSURANCE REIMBURSEMENT**

If you have a health insurance policy, it may or may not provide 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 the full payment of my fees.** For that reason, it is very important that you find out exactly what mental health services your insurance policy covers. 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 I will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear up any confusion, I am willing to call the company on your behalf.

Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. However, I will file insurance on your behalf. My office verifies insurance benefits in an attempt to obtain accurate information regarding your co-payment and/or deductibles. However, it is quite common for insurance companies to pay differently than what they quoted at the time of your initial 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 the number of sessions used for each authorization. Therefore, to avoid any disruption in your treatment or 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 authorized. I can then submit additional clinical information to obtain an authorization for additional sessions.

You should also be aware that your contract with your health insurance company requires that I provide the company with information relevant to the services that I provide to you. At a minimum, I am required to provide a clinical diagnosis. 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. However, **this information will become part of the insurance company files and will probably be stored in a computer.** Though all insurance companies claim to keep such information confidential, I have no control over what they do with the information once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report that I submit, if you request it. By signing this Agreement, you agree that I can provide the requested information to your carrier.

It is important to remember that you always have the right to pay for services without using your insurance if you wish to increase the level of confidentiality of your records.

