West Georgia Psychological Services, L. L. C.

Tina M. Caudill, Psy.D., Licensed Psychologist
6264 Hospital Way, Douglasville, GA 30134
Phone: (678) 232-9078 Fax: (866) 489-2642
Office Manager: (678) 977-7345

Letter of Introduction

Enclosed Documents

Thank you for choosing my practice. Enclosed you will find the various forms needed for intake including:

-Adult Intake Form
-Blanket Authorization to Release Information
-Specific Release of Information
-General Information and Consent to Treat Form
-Georgia Notice Form (HIPAA)
-Georgia Notice Form Signature Page
-Payment Agreement
-Attendance Agreement

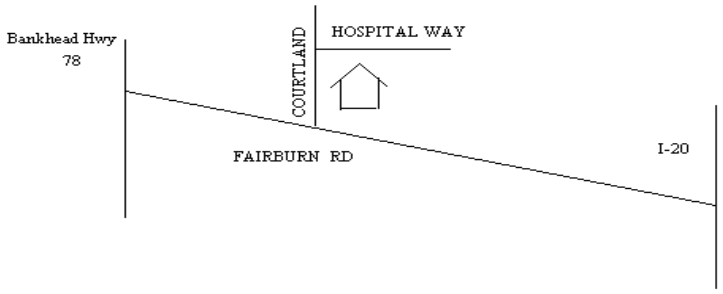
It is very important to have all the information filled out prior to the first session, as required by law and psychological ethics. The Adult Intake Form will be discussed in great detail during the first session, so please be as detailed as possible when describing the history.

What to bring to the first session

Please be sure to bring your insurance or Medicaid card to the first session, as I am unable to provide services without a copy in the client's chart. **Also bring this intake packet completed fully, as I will not be able to meet with you without this information prior to our initial meeting time.**

Directions

The office is located on Hospital Way **(NOT HOSPITAL DRIVE)**, although the front of the house is actually on Courtland St. Courtland St. is off of Fairburn Road in Douglasville. If you are coming from I-20, you would travel north on Fairburn Road (one mile) and take a right on Courtland. If you are coming from 78 (Bankhead Hwy), Courtland is roughly 5-6 blocks on your left hand side. The practice is the first house on the right when you turn on Courtland and is very easy to find. Courtland is the street across from Gables Sporting Goods. There is a sign in front of the house that says the name of the practice.



I do not have a support staff currently, therefore; when you come for your appointment, please take a seat in the waiting room until your appointment time, as I may be in with another client.

Thanks again for choosing my practice and I look forward to working with you.

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Licensed Psychologist

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Identifying Information/Presenting Problem:

Name_____ Date of Birth:_____

Age:_____ Date of Evaluation/Intake:_____

Address:_____ City:_____ Zip Code:_____

Phone Number:_____ Alternative Phone:_____

Who referred you:_____

Primary Reason for Services/ Presenting Problem:_____

Family History:

Current Members of the Household:

Name Age Relationship How do they get along with others in home?

1_____

2_____

3_____

4_____

5_____

6_____

Describe your relationships with household members:_____

_____

Number of children and ages:_____

Where are any children outside of the home?:_____

_____

Are you currently married or with a partner?_____ Length of this relationship?_____

History of separations or divorce?_____

Describe what your relationships have been like with significant others (partners)_____

_____

Department of Family and Children Services (DFCS) Involvement:

Is DFCS currently involved? ( )Yes ( )No How long have they been involved?_____ What County?_____

Who is your DFCS Case Manager:_____ Case Managers Phone Number:_____

Describe why DFCS is involved:_____

_____

_____

Has DFCS been involved at times in the past? ( )Yes ( )No Dates:_____

Describe why DFCS was involved in the past:_____

_____

What is being required of you by DFCS (case plan or reunification plan): _____

_____

What else do we need to know about your involvement with DFCS?_____

_____

Parenting:

How do you view your parenting skills?_____

What do you need to improve as a parent?_____

What do you use for discipline?_____

Have you used physical discipline? Explain:_____

Have you ever had problems providing the basic needs for your children (utilities, food, clothing, housing) ?_____

Describe:_____

Family of Origin:

Please describe your childhood:_____

Describe your current and past relationship with your mother :_____

_____

Describe your current and past relationship with your father:_____

_____

Does either of your parents (or caregivers) have drug or alcohol use/abuse now or in the past? Describe: _____

_____

Does either of your parents (or caregivers) have domestic violence issues or significant conflict? Describe:_____

_____

How many brothers and sisters do you have? _____ Describe your relationships with siblings?_____

_____

Does anyone in your extended family (siblings and parents) have a history of mental health problems? Describe:_____

_____

History of Trauma:

Please **check** and **describe** any of following that have occurred anytime in your life, either as the victim or as a witness:

( ) Physical Assault or Abuse:_____

( ) Emotional Abuse:_____

( ) Domestic Violence or Exposure to Physical Conflicts:_____

( ) Neglect (Not having basic needs met):_____

( ) Sexual Abuse: _____

Describe anything else you have experienced that may have been traumatic or greatly impacted you in your life:_____

_____

Social/Emotional Functioning

Describe your personality:_____

_____

What would you like to change about yourself?_____

How do you deal with frustration?:_____

Do you feel you have anger issues? Describe:_____

What are your strengths?:_____

What are your weaknesses?_____

What are your fears (what are you afraid of)?_____

How many close friends do you have? _____ What do you do with friends?_____

Describe your relationships with others:_____

How do you spend your free time?_____

Legal History

Please list and explain any legal charges you have had (even if the charges were reduced or dropped), include dates:_____

_____

_____

Have you ever been: ( ) on probation ( ) on parole ( ) incarcerated ? Provide reason and dates:_____

_____

_____

Please describe if you have any family or friends (current or past) that have legal charges: _____

_____

Substance Abuse:

How often do you drink alcohol? _____ How much per sitting?_____

Have you ever used or abused any drugs in your life? Describe:_____

_____

Have you ever had any treatment related to substance use? Describe: _____

_____

Do you smoke cigarettes? ( )Yes ( )No Amount per day?_____

Please indicate if you have any family or close friends (current or past) who have an alcohol or drug problem:_____

Medical History:

Significant medical problems during childhood:_____

Current health and medical problems: _____

(Past: include age):_____

Current medications:_____

Past medications for behavioral/emotional problems:_____

Other medical history:_____

Describe your sleeping patterns:_____

Is there a history of nightmares? (Describe):_____

Describe your eating patterns:_____

Mental Health History:

What current mental health services (counseling and/or psychiatrist) are you receiving?_____

_____

What mental health services have you received in the past? (include dates):_____

_____

What have you been diagnosed with (current or past)?_____

Have you ever received a psychological assessment in the past?_____ Date:_____

Results of testing:_____

Have you ever thought about or attempted to harm yourself or someone else? Describe:_____

_____

Circle which mental health services you feel would assist in addressing the current difficulties?

Individual Therapy Group Therapy Family Therapy Medication Management Other:_____

Employment & Educational History:

Current Employment:_____ Amount of time at current employment:_____

How many hours do you work in a typical week?_____ Approximate Income:_____

If not employed, how long have you been without work and explain why?_____

_____

How many jobs have you had in the last 5 years? (describe):_____

Describe your current level of job satisfaction:_____

Describe your relationship with others at your job:_____

Highest Level of Education: _____

Did you have any learning difficulties in school?_____

Did you have frequent discipline problems while in school? Explain:_____

_____

Daily Living Skills:

Describe your daily activites:_____

_____

Do you have difficulties managing money?_____

Number of hours your watch television or use computer for leisure per day:_____

Do you prepare your own meals or eat out often?:_____

Do you have transportation? (Describe):_____

Describe general housekeeping duties you perform weekly:_____

_____

Do you have your own housing? Explain:_____

How many different residents have you lived in over the last 5 years?_____

Are there any history of developmental delays, explain:_____

Please check all symptoms that apply: (Please write any symptoms not listed at the bottom)

____ Low Intelligence
____ Learning Problems
____ Social Isolation
____ Lack of Eye Contact
____ Obsession with Specific Topics/thoughts

____Attention Problems
____Problems Listening
____Problems with Organization
____Losing Things Easily
____Distracted Easily
____Forgetful
____Excessive Energy
____Impulsive/Acting without Thinking
____Excessive Talking
____Interrupting Others

____Bullying/Threatening Others
____Getting into Fights
____Harmed or Threatened Others with a Weapon
(Knife, Gun, Bat, Bottle, etc.)
____Cruel to Animals
____Stealing
____Frequent Lying
____Damaging Own or Others Property
____Getting into Frequent Arguments with Others
____Losing Temper Easily
____Feeling Angry Often

____Hearing Voices
____Seeing Things Others Don't
____Paranoia (feel others are out to get you)

____Sexual Problems
____Gambling Problems
____Identity or Gender Issues

____Excessive/Binge Eating
____Making Yourself Vomit or Use of Laxatives
____Excessive Dieting or Exercise

____ Depressed Mood
____ Lack of Pleasure in Activities
____ Weight Loss or Gain
____ Insomnia or Oversleeping
____ Feeling Restless or Slowed Down
____ Loss of Energy
____ Feeling Worthless or Guilty
____ Poor Concentration
____ Thoughts of Death
____ Increased Self Esteem
____ Less Need for Sleep
____ More Talkative than Usual
____ Racing Thoughts
____ Increased Pleasurable Activities
(e.g. sex, shopping, etc.)

____ Pounding Heart, Increased Heart Rate
____ Sweating
____ Shaking or Trembling
____ Feeling Like Choking
____ Chest Pain
____ Nausea and/or Stomachaches
____ Feeling Dizzy, Lightheaded, or Faint
____ Feeling Like Your Going Crazy
____ Fear of Dying
____ Chills or Hot Flashes
____ Fear of Leaving the House
____ Fear of Social Situations

____ Recurrent Thoughts or Images
____ Constant Worrying or Nervousness
____ Repetitive Handwashing, Cleaning, etc.
____ Other Repetitive Behaviors
(that reduces anxiety or nervousness)

____ History of Trauma or Abuse
____ Fear Related to Trauma or Abuse
____ Recurrent Thoughts Related to Trauma
____ Avoiding Situations Related to Trauma
____ Blocking Out Memories Related to Trauma
____ Extreme Startle Response (jumpiness)
____ Sleep Problems and/or Nightmares

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General Information and Consent Form

Services Provided

Dr. Tina Caudill, licensed psychologist, is an individual practitioner who provides individual, marriage, family, and group therapy services. Dr. Caudill also has extensive training in administering psychological evaluations. Dr. Caudill has specific training in play therapy, therapeutic use of art, cognitive/behavioral interventions, and interpersonal therapy. A copy of Dr. Caudill's vita (professional resume) is available for review if requested.

It is important for clients to understand that psychotherapy can have both benefits and risks. This process often involves discussion of personal challenges that can elicit uncomfortable feelings such as sadness, guilt, anger, and frustration. However, therapy has also been shown to have many benefits such as increasing interpersonal relationships, strengthening problem solving abilities, increasing insight into maladaptive patterns, and reducing feelings of distress. It is important to note that there are no assurances of these benefits and progress is often dependent upon the motivation and participation of the client.

The first several appointments are typically devoted to reviewing the client's history, discussing the nature and purpose of the therapy process, explaining client's rights, determining a diagnosis, and developing a treatment plan. Client feedback regarding the therapy process is highly encouraged and formal feedback/progress forms are available. Progress will be evaluated on a regular basis. Many therapy issues can be addressed in short-term therapy, but there are some circumstances that warrant long-term treatment, especially those involving a significant history of abuse and/or neglect.

General Policies

Dr. Caudill is available by phone 24 hours 7 days a week and all phone calls will be returned in a timely manner. In contrast, phone contact outside of business hours (Monday-Friday 9:00 am to 5:00 pm) should be limited to emergencies. If there is a severe threat or act involving harm to self or others, please go to your nearest emergency room immediately. Scheduling and routine questions can be addressed via e-mail if you sign indicating that this is an acceptable form of communication, but please limit confidential therapy related issues to face-to-face appointments, as confidentiality cannot be fully protected via e-mail and I will not be able to give you the support you need.

Please arrive to appointments on time. Missed appointments reduce Dr. Caudill's capacity to provide services to other clients, as the number of appointment times are limited, especially during peak hours (e.g. after school). If a pattern of late arrival or missed appointments develops, your regular appointment time could be given to another client and you may be asked to take an appointment time during non-peak hours. In extreme circumstances, therapy may be terminated. Please give Dr. Caudill 48 hours notice of cancellation or as early as possible, although it is understood that some rare circumstances are unavoidable (e.g. emergencies, sickness, etc.).

Confidentiality

In keeping with the standards of the American Psychological Association (APA), as well as state and federal law, all services provided by Dr. Caudill are kept confidential. A release of information must be signed for information to be disclosed to any party in most circumstances. Psychologist have a legal responsibility to disclose pertinent information without consent when a client is likely to harm himself/herself or others, when there is reasonable suspicion of child or elder abuse, and when there is a valid court order. Please read and sign the provided information about confidentiality and HIPAA laws. If you have any additional questions about confidentiality or any of the information on this form, please feel free to discuss it with Dr. Caudill.

Please sign below to indicate that you have read, understand and agree to participate in psychological services in accord with the above outlined policies.

Print Client Name:_____ Sign:_____ Date:_____

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AUTHORIZATION AND RELEASE FOR THE EXCHANGE OF CONFIDENTIAL AND PRIVILEGED INFORMATION

I, _____ hereby authorize the written and verbal exchange of any confidential or privileged information between Tina Caudill, Psy. D. and any Court or any Health, Education, or Legal Professional and any other person who, in Dr. Caudill's discretion, might be relevant to my contact with this office. Any exceptions to this exchange of confidential or privileged information are identified below. The exchange of this information will only be used to coordinate care and ensure quality treatment. The client or guardian will typically be informed in advance about the shared information to ensure that specific verbal consent is obtained in addition to this release.

I understand that Dr. Caudill, like most professionals, consults with other professionals as part of normal practice, mutual professional feedback, supervision and that Dr. Caudill uses professional test scoring services. I agree that this release also includes such professional consultation and use of such service, but understand that precautions will be taken to guard sensitive information. In addition, support staff may also view confidential information in the context of their work activities, but are required to keep such information private and confidential as the terms of their employment.

I understand that many insurance companies and Medicaid/Peachstate often require the disclosure of personal information including but not limited to diagnosis, level of functioning and treatment plans prior to gaining authorizations and reimbursement for services. I agree that such information can be released to such entities at the discretion of Dr. Caudill, but only the relevant information will be disclosed.

I understand that without this release my records would otherwise be protected under the Federal and State Confidentiality Regulations and could not be disclosed except in accordance with those regulations. I understand that it is my right to revoke this release at any time. I understand and agree that even if I revoke to release, the laws of the State of Georgia require Dr. Caudill to disclose privileged information in situations of suspected child abuse, of suspected potential harm to oneself or another and in instances where the court shall order the disclosure of privileged information or shall subpoena records. In addition, any progress notes require an additional specific release and are not covered under this agreement, as they are held at the highest level of confidentiality.

In considerations of Dr. Caudill's agreement to perform this service for me, I hereby release Dr. Caudill and each of the above parties with whom Dr. Caudill exchanges and/or releases information, from all liability, legal, professional, financial, or otherwise, that might directly or indirectly result from the release or exchange of any information that might be relevant to this consultation or evaluation. I fully understand, agree, and take sole responsibility that the information released may be detrimental and damaging to me personally, to me financially, and to me legally. I understand and agree that this is a legally binding document, that I have had the opportunity to consult with an attorney on this matter if I desire, that I fully understand the rights and privileges that I now waive by signing this agreement, and that I give this release, authorization, and consent of my own free will. I also agree that a photocopy of this form and my signature below is as valid as the original.

Any exceptions not included in the release:_____

_____ _____

Signature **Client Name (please print)**

Executed ____/_____/_____ in Douglas County, Georgia

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Georgia Notice Form

This notice describes how psychological and medical information about you may be used and disclosed, as well as how you can get access to this information. Please review carefully.

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 clarify 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 healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations: are activities that relate to the performance and operations of my practice. Examples of health care operations quality assessments and improvement activities, business-related matters such as audits and administrative services, and case management or care coordination.
-Use: applies to only activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
-Disclosure: applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or heath 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 circumstances 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 an authorization before releasing your psychotherapy notes, which are notes I have made about our conversations during a private, group, joint, or family therapy counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke to an authorization to the extent that I have relied on that authorization or if the authorization will obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under their policy.

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 it to the proper authorities according to state law
- ***Adult and Domestic Abuse***-If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury other than by accidental means, or has bee neglected or exploited, I must report that belief to the appropriate authority
- ***Health Oversight Activities***-If I am subject of an inquiry by the Georgia Board of 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 request is made about the professional services I provided you or the records there of, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered. You will be informed in advance if this is the case.
- ***Serious Threat to Health or Safety***-If determined, 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***-I may disclose protected health information regarding you as authorized by and the extent necessary to comply with laws related to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

Client's Rights and Psychological Duties

Client's Rights

- Right to Request Restrictions-You 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 Communication by Alternative Means and at Alternative Locations-You have the right to request and receive confidential communication of PHI by alternative means and locations (ex: you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address)
- Right to Inspect and Copy-You 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 amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with the details of the amendment process.
- Right to an Accounting-You generally have the right to receive an accounting of the disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to Paper Copy-You have the right to obtain a paper copy of the notice from me upon request, eve if you have agreed to receive the notice electronically

Psychologist'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 this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and provide you with a copy of revised material at the next session or by mail.

Complaints

- If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me to express your concern.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date, Restrictions, and Changes to Privacy Policy

- This notice will go into effect January 2nd 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 revised notice by U.S. mail.

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I have been presented with a copy of the Georgia Notice Form regarding the privacy of my personal health information. I have read the notice, and understand my rights and the psychologist's obligations to protect the unauthorized dissemination of my records.

I am aware that if I have any questions or concerns, I can call or meet with the psychologist to discuss these concerns. I may also be provided with a copy of the Georgia Notice Form to keep for my own personal records, upon request.

I will notify the office if any changes need to be made regarding my personal health information.

_____ _____

Signature Date

_____

Print Name

_____

Client's Name if Signed by Guardian

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Authorization Form

This form, when completed and signed by you, authorizes Tina M. Caudill, Psy. D. and/or her administrative and clinical staff to release/receive all information verbally or written regarding the following client:

Client's Name: _____

Client's Date of Birth: _____

This information should be released:
Name/Organization/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

I am requesting my psychologist to release confidential information written or orally. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client or Personal Representative (Guardian) Date

_____
Client Name (print)

I the authorization is signed by a personal representative (guardian) of the patient, a description of such representative's authority to act for the patient must be provided.

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Payment Agreement

I understand that all copays are due prior to receiving services. By having all checks and payments ready before the appointment ensures that time will not to be taken away from the therapy session to collect funds.

I agree that all payments are ultimately my responsibility if insurance or Medicaid fails to pay for services for any reason. Lapses in coverage and changes to plans should be communicated to the service provider immediately. Collection services will only be utilized in extreme situations only after all other methods used to collect funds have been exhausted.

I understand that all insurance companies and Medicaid will ask for a diagnosis in order to pay for services and that some plans will request a full treatment plan for extended services. Many insurance companies exclude the diagnoses of Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disabilities (LD), and Developmental Disabilities (DD) for payment and therefore payment may ultimately be my responsibility.

I understand that Medicaid will not allow my child to see more than one mental health service provider (e.g. psychologist, psychiatrist) in a period of one week and will plan accordingly, as well as discuss coordination of services with the providers.

I understand that both Medicaid and insurance companies often only allow a certain number of therapy sessions per calendar year; therefore, it is my responsibility to inform the provider of any past services that have been received. In addition, psychological evaluations can typically only be conducted once a year; therefore, it is also my responsibility to inform the service provider of any past evaluations.

Although it is understood that from time to time brief phone consultations will be required as a part of services, extensive and/or ongoing phone contacts are a service that will require a fee; therefore, it is necessary to limit phone contacts to scheduling issues and emergency situations, as most treatment issues can be discussed in the next scheduled therapy session.

Below is the standard out of pocket fee schedule for psychological services. There is a sliding scale available (please discuss with provider) for individuals with limited income for some services (e.g. therapy), but there is no sliding scale for the administration of psychological evaluations and forensic services (e.g. court appearances). The fee schedule for insurance and Medicaid is determined by the particular organization and agreed upon by the provider as a condition of participation with each plan. In contrast, out of network services may be higher than the insurance company is willing to pay.

PAYMENT CAN BE IN THE FORM OF CHECK, CASH, OR MONEY ORDER, NOT CREDIT/DEBIT CARDS

Fee Schedule for Psychological Services

Service	Standard Fee
Individual Therapy Session (45 minutes)	$135.00
Family Therapy Session (45 minutes)	$135.00
Group Therapy Session (60-75 minutes)	$75.00
Forensic Services (60 minutes)	$200.00
Retainer Required for All Court Appearances	$500.00
Phone Consultation (per 15 minutes)	$25.00
Bounced Check Fee	$35.00
Psychological Evaluation: Includes an Intake and Feedback Session	
Full Brief Psychological Evaluation	$675.00
Comprehensive Psych Evaluation or Evaluation of Child Custody	$850.00
Adult Parenting or Custody Evaluation	$1,000.00
Addition of Competency Evaluation to Full Testing	$300.00

Other Arrangement:_____ _____

Please sign below that you have read and agree to the above outlined payment agreement. If you have any questions or concerns regarding this agreement, please discuss with the provider before signing.

_____	_____	_____
Print Client Name	**Signature of Client or Guardian**	**Date**

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Permission To Leave Message and E-mail Agreement
(Addendum to Confidentiality Agreement)

Client's Name:_____ Date of Birth:_____

INITIAL THOSE THAT APPLY BELOW:

_____ I give permission for West Georgia Psychological Services to leave a message on my answering machine, voice mail service, or with others answering the phone for any numbers I provide as part of the intake paperwork or at the initial phone consultation.

_____ I **do not** give permission for West Georgia Psychological Services to leave a message on my answering machine, voice mail service, or with others answering the phone for any numbers I have provided as part of the intake paperwork or at the initial phone consultation.

_____ I give permission for West Georgia Psychological Services to leave a message on my answering machine, voice mail service, or with others answering the phone for only the following number(s):

_____

_____

_____ I give permission for West Georgia Psychological Services to correspond with me via e-mail regarding basic information about the above client and I understand there are limits to confidentiality by using e-mail as a form of communication. **(For use in scheduling, cancellations, and payment issues).**

_____ I give permission for West Georgia Psychological Services to correspond with me via e-mail regarding the above client **regarding all clinical information**, but I understand there are limits to confidentially by using e-mail as a form of communication.

This agreement is binding for as long as you are receiving treatment at West Georgia Psychological Services, but you have the right to withdraw such permission in writing at any time during treatment.

Signed:_____ Date:_____

West Georgia Psychological Services
Client's Rights and Responsibilities Statement

Clients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment
- Their treatment and other client information kept private. Only where permitted by law, may records be released without client permission
- Easily access timely care in a timely fashion
- Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan
- Share in the developing of their plan of care
- Information in a language they can understand
- A clear explanation of their condition and treatment options
- Information about the insurance company or payment source, its practitioners, services and role in the treatment process
- Information about clinical guidelines used in providing and managing their care
- Ask their provider about their work history and training
- Give input about the Client's Rights and Responsibility policy
- Know about advocacy and community groups and prevention services
- Freely file a complaint or appeal and to learn how to do so
- Know of their rights and responsibilities in the treatment process
- Receive services that will not jeopardize their employment
- Request certain preferences in a provider
- Have provider decisions about their care made without regard to financial incentives

Members have the responsibility to:

- Treat those giving them care with dignity and respect
- Give providers information they need. This is so providers can provide the best possible care
- Ask questions about their care. This is to help them understand their care
- Follow the treatment plan. The plan of care is to be agreed upon by the client and provider
- Follow the agreed upon medication plan
- Tell their provider and primary physician about medication changes, including medications give to them by other doctors
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits
- Let their provider know when the treatment plan is not working for them
- Let their provider know about problems with paying fees
- Report abuse and fraud
- Openly report concerns about the quality of care they receive

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____ _____ _____

Signature Print Client Name Date

The signature below shows that I have explained this statement to the client. I have offered the member a copy of this form.

_____ _____

Provider Signature Date

West Georgia Psychological Services, L. L. C.

Tina M. Caudill, Psy.D., Licensed Psychologist
6264 Hospital Way, Douglasville, GA 30134
Office Manager: (678) 977-7345 Phone: (678)232-9078 Fax: (866) 489-2642

Attendance Agreement

Due to a high number of no shows and last minute cancellations, an attendance policy has been instituted to ensure that all clients are able to get an appointment in a timely manner. This policy is designed to prevent large openings in the schedule that could be used by families in high need.

Please be advised that **testing appointments** (psychological evaluations) last several hours and a take up a large portion of the schedule. Therefore, if you do not show up for a testing appointment, it will not be rescheduled or there will be a **fee of $50**. In addition, **at least 48 hours advance notice of cancellation (not including weekends)** is required for testing to allow enough time to fill the open testing spot with another client. Cancelled testing appointments without 48 hours notice will only be rescheduled in very rare circumstances that are considered an emergency.

There are also a very limited number of after-school therapy appointment times due to a high demand. Therefore, at least 24 hours advance notice is required for canceling a therapy session except in rare circumstances that are considered an emergency. Failure to give 24 hour notice will include a **$25 no show fee** and repeated occurrences may result in losing your regularly scheduled time slot.

For intake appointments, it is necessary to have all paperwork with you and completed prior to the time of the intake session. I will not be able to meet with you if you are more that 10 minutes late for this appointment because I will not have time to get through all the needed information. If I have to reschedule your intake appointment because you are more than 10 minutes late or you have not completed the paperwork in advance, there will be a **$25 fee** which much be received before rescheduling.

Please sign below that you have read and agree to the attendance policy.

_____
Client Name

_____ _____
Signature of Client Date