Georgia Psychology & Counseling

Phone (706) 364-4599
Fax (706) 364-4589
211 Pleasant Home Road, Ste. G1
Augusta, GA 30907

Provider: Adrian Janit, PhD (Licensed Psychologist, GA & SC)

Date: _____ **Client's name:** _____ **DOB:** _____ **Age:** ____

Gender: M F **Identifies as (if applicable):** _____ **Ethnicity (optional):** _____

SSN: _____

***Parent/Guardian's name** (if applicable)**:** _____ **Relationship to client:** _____

***Parent/Guardian's phone number:** Home _____ Mobile _____

Client's marital status: _____ **Client's job title, or child's school grade:** _____

Client's employer or school: _____

Client's phone numbers: Home_____ Mobile _____ Other_____

Client's Address: _____City_____ State _____ Zip_____

Email Address: _____ (if client is under 18, parent/guardian's email)

May we contact you to remind you of appointments? Yes No **May we leave a text message?** Yes No

Primary Insurance Name: _____ **Member number:** _____
Group Number: _____ **Insurance phone numbers (claims/benefits):** _____
Subscriber's Name: _____ **Relationship to client:** _____
Subscriber's SSN: _____ **Subscriber's DOB:** _____

Secondary Insurance Name: _____ **Member number:**_____
Group Number: _____ **Insurance phone numbers (claims/benefits):** _____
Subscriber's Name: _____ **Relationship to client:** _____
Subscriber's SSN: _____ **Subscriber's DOB:** _____

Previous psychological testing/counseling/therapy? Yes No **Approximate dates:** _____

Has client been evaluated by a psychiatrist? Yes No **Name:** _____ **Approx. dates:** _____

Current medications for psychological conditions: _____

Presenting Problem: _____
Date symptoms began (approximate): _____
Who referred you? How did you hear about us? _____

Signature: _____ (If client is under 18, parent/guardian signs)

Please present your Insurance card to the front desk.

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PARENTS/LEGAL GUARDIANS

Please complete this form if you are bringing your child (under age 18) for evaluation or therapy.

This is about the child's other parent/legal guardian.

The child's biological parents are:

- ☐ **Not married**
- ☐ **Married and together**
- ☐ **Married and separated**
- ☐ **Divorced**
- ☐ **The other biological parent/guardian is deceased**

What is the current custody agreement? Sole ☐ Joint ☐ Other: _____

Who has legal decision-making power for non-emergency medical/psychological treatment?

Sole ☐ Joint ☐ Other: _____

(If unsure of custody/decision-making, please provide legal document/parenting plan)

Are you currently in a legal process to determine custody of the child? **YES** ☐ **NO** ☐

If YES, please be advised that Dr. Janit does not participate in custody evaluations or legal matters. We can refer you to a forensic psychologist who handles such matters.

Dr. Janit prefers to inform the other parent/legal guardian that the child is being evaluated/treated, and give them the opportunity to provide information that may be useful.

I consent to allow Dr. Janit to contact the child's other parent. **YES** ☐ **NO** ☐

Other parent/guardian's name: _____ **Phone or email:** _____

Signature: _____ (Parent/Legal Guardian) **Date:** _____

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Informed Consent

Consent: I agree to be evaluated and treated by **Adrian Janit, PhD**, a licensed psychologist in GA and SC.

Purpose: I understand that any assessment procedures I receive are for the purpose of clarifying diagnoses and generating a treatment plan.

Withdrawal: I understand that I may withdraw from this evaluation and treatment at any time, and I am free to leave at any time.

Missed Appointments: I understand that if I miss an appointment without calling to cancel with 24 hours' notice, I will be charged a **no-show/cancellation fee of $60**. Two consecutive no-shows will result in all further appointments being cancelled. If I contact you for further appointments, only one appointment at a time will be scheduled. If I miss an excessive number of appointments over time, I may be referred to another facility.

Court/Legal Cases/Litigation Limitation: I understand that Dr. Janit does not accept cases that involve the court system, lawyers, DFCS, juvenile justice, custody, or any other legal matters.
I understand that I will not involve or engage Dr. Janit in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. If Dr. Janit does speak with any of the aforementioned people, a minimum charge of $150 per hour will be paid by me in advance of any such conversation. In the event that I wish to have a copy of my file, and I execute a proper release, Dr. Janit will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena Dr. Janit to testify at a deposition or a hearing, I would be responsible for his expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena Dr. Janit, he may elect not to speak with my attorney, and a subpoena may result in Dr. Janit withdrawing as my counselor.

Video Monitoring: These offices are video-monitored and recorded, for liability and safety purposes. No sound is recorded, only video.

Confidentiality: All my personal information will be kept confidential, except:

- My insurance company (if applicable) will receive information about my attendance, my presenting problem, and my diagnosis. The insurance company may require information about why my treatment is necessary.

- Dr. Janit is ethically and legally obligated to contact the appropriate authorities or treatment facilities if I give the impression that I am at risk of harming myself or others. If clients under the age of 18 disclose a history or risk of self-harm or other-harm, their parent/guardian will be alerted.

Parents/guardians: I agree that I will not leave any children under 18 unattended in the office, and I will not leave the office while my child is being evaluated or treated.

If client is under 18 years old, the parent/guardian should sign this form.

Printed name: _____ Signature: _____ Date: _____

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize *Georgia Psychology and Counseling* to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtain payment from third party payers (e.g. my insurance company)
- The day-to-day operations of the practice/office.

I have also been informed of and given the right to review and secure a copy of *Georgia Psychology and Counseling's* Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that *Georgia Psychology and Counseling* reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that *Georgia Psychology and Counseling* is not required to agree to these requested restrictions. However, if *Georgia Psychology and Counseling* does agree, they are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____

Print Patient Name _____

Signature _____

Relationship to Patient _____

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Statement of Patients' Rights

Patients 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.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities 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.

Statement of Patients' Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver 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 member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't 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.

Patient Signature Date
(Parent/Guardian sign if patient is under 18 yrs old)

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

Provider Signature Date

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Authorization Consent Form

HIPAA AGREEMENT:

I have read and agree to the Patient Service/HIPAA agreement provided to me by *Georgia Psychology & Counseling*. I have read and understand the Georgia Notice of Psychologist's Policies and Practices. I have read and understand the Patient's Rights and Responsibilities Statement.

_____	_____	_____
Patient Name	Patient (Parent/Guardian) Signature	Date

INSURANCE AUTHORIZATION:

I authorize *Georgia Psychology & Counseling* the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to be paid to *Georgia Psychology & Counseling* for services provided. *Georgia Psychology & Counseling* will attempt to collect from my Insurance Company; however, I am financially responsible for amounts insurance does not pay. If the insurance company gives us incorrect information that results in you owing additional money for services, you are responsible for the balance due. If you give us incomplete or inaccurate insurance information, you will be responsible for the balance if we are unable to collect in full from your insurance plan(s).

_____	_____	_____
Patient Name	Patient (Parent/Guardian) Signature	Date

CANCELLATION POLICY:

I understand it is my responsibility to contact *Georgia Psychology & Counseling* 24 hours in advance of cancellation of appointments with Dr. Janit. I will be charged a $60 fee for missed appointments without 24-hour prior notification.

_____	_____	_____
Patient Name	Patient (Parent/Guardian) Signature	Date

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Notice of Patient Financial Responsibility

Our office provides services in good faith that it will be appropriately compensated. It is the patient's/guarantor's responsibility to understand their individual health policy and its mental health coverage and/or restrictions. Any services not covered by health insurance will be the full financial responsibility of the patient/guarantor.

Our office will gladly file with your primary and secondary health insurance on your behalf. Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information. Patients must provide our office with a copy of your current insurance card(s) as well as a state issued photo ID or driver's license.

Deductibles, copayments, and coinsurance are due at the time of service. **Outstanding patient balances must be paid prior to new appointments being made, test results being released and any requests for medical records fulfilled**.

If the insurance company requests information directly from the patient (*example: Updates to Co-ordination of Benefits, accident/incident details*) and the information is not submitted in a timely manner, then the claim will become the full responsibility of the patient/guarantor. Interest, penalty, collection costs and legal costs incurred in order to obtain patient payment become the responsibility of the patient/guarantor.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Georgia Psychology & Counseling for services.

_____
Patient Name

_____ _____
Patient (Parent/Guardian) Signature Date

Pre-authorized Credit/Debit Card on File

□ If ***Medicaid, Amerigroup, Wellcare, Peachcare***, or ***Care Source*** is the **PRIMARY** insurance, do not fill out this form.

Clients **MUST** have a valid credit/debit card on file with our office. Due to insurance deductibles, non-covered services, rejected claims, no-shows, and late cancellations, it has become necessary to keep your credit/debit card details on file, and to charge your credit/debit card for services not covered by insurance. We will attempt to get payment from you first before we charge the card. If you do not respond to our attempts, which may be in the form of mailed statement, email or in person at our office, we will then charge the card on file. ***If you do not leave a valid credit/debit card on file, payment in full for the entire cost of the visit will be expected at time of service, regardless of your insurance.*** If insurance eventually reimburses us, we will either refund you or apply your credit to future co-pays and deductibles.

Please read and agree to the following:

"I understand that *Georgia Psychology and Counseling* will bill my insurance company for the services I receive. Any fees that my insurance company does not pay, such as deductibles, non-covered services, rejected claims, no-shows, and late cancellations, are my financial responsibility.

I hereby give *Georgia Psychology and Counseling* permission to charge my credit/debit card for services not paid by my insurance carrier. I understand that this form is valid for three years unless I cancel the authorization in writing. If my credit/debit card is declined and *Georgia Psychology and Counseling* is unsuccessful in reaching me, I understand that when my balance reaches 120 days, *Georgia Psychology and Counseling* will seek the help of a collection agency to receive payment."

Patient's Name: _____

Cardholder's Name: _____

Cardholder's Billing Address: _____

Cardholder's Phone number: _____

___Visa ___MasterCard ___Discover ___Amex ___Other

Card Number: _____ Exp. MM/YY: _____

Cardholder's Signature: _____ Date: _____

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Two-Way Records Release

Complete this form <u>only</u> if you would like us to share information with another facility or person.

Date: _____ **Client's name:** _____ **DOB:** _____

Parent/Guardian's name (if applicable)**:** _____ **Relationship to client:** _____

If there is a custody agreement: Shared Sole Joint Other: _____

Who has legal decision-making power for mental health treatment? _____

***SIGNATURE* of legal decision-maker for treatment:**_____

I authorize a two-way release of records/information between Dr. Adrian Janit and:

Facility/Person: _____

Phone: _____ **Fax:** _____

Type: Entire record Attendance Insurance Evaluation Results Other_____

Valid for: 3 months 6 months 1 year

Facility/Person: _____

Phone: _____ **Fax:** _____

Type: Entire record Attendance Insurance Evaluation Results Other_____

Valid for: 3 months 6 months 1 year

Facility/Person: _____

Phone: _____ **Fax:** _____

Type: Entire record Attendance Insurance Evaluation Results Other_____

Valid for: 3 months 6 months 1 year