Kate Avinger, Psy.D., P.C.
Licensed Psychologist (GA 3056)
485 Huntington Rd., Suite 201, Athens, GA 30606
Office 706-546-8440 Fax 706-369-0390

**Initial Evaluation**

**Demographic Information**
**(Please complete all questions on this form)**

**Date:** _____

**Patients Name:** _____

**Address:** _____

_____

**Phone (home):** _____ **Phone (work):**_____

**Date of Birth:** _____ **Email:** _____

**Guardianship (for children and adults when applicable):** _____

**Legal Gender:**___Male ___Female
**Identified Gender:**___ Male ___Female

**Family Members:**

| Name | Age | Sex | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Employer:** _____ **Occupation:** _____

**School (for children, and adults when applicable):** _____

_____

**Referral Source:** _____

**Insurance Information:**
Insurance Company/HMO: _____ Phone: _____

Member ID #: _____Managed Care Company: _____

Subscriber Name: _____ Group Number: _____

Employer: _____

Claims Address: _____ Phone: _____

**Emergency Information:**
Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

**Advance Directives:**
I have an Advance Directive/Instruction for Mental Health Treatment: ___Yes ____No

I request that payment of authorized third party benefits be made on my behalf to Dr. Kate Avinger for any services rendered by him or his assistants. I understand my signature also authorizes release of any information contained in my records to any relevant insurer, or its assignees, necessary to pay a particular claim.

By my signature, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason. These fees include any/all services performed by Dr. Avinger, including any/all forensic (court) appearances, court preparation, and travel. In some cases, a third party may be contacted for confidential collections.

A minimum for 24 hours of cancellation of your appointment is required. I understand that payment is due at the time services are delivered. I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those fees in the event that I or my child fails to show up for an appointment or cancellation of an appointment with less than twenty four hours notice.

_____ _____
Signature of Patient or Responsible Party Date

# FINANCIAL POLICY

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED

AN ACCOUNT 60 DAYS OLD WILL BE CONSIDERED DELINQUENT AND IS SUBJECT TO BEING TURNED OVER TO AN OUTSIDE AGENCEY FOR COLLECTION

The current rates for services provided by this office are listed below. We welcome frank discussions of services and fees *prior* to treatment in order to avoid misunderstandings. Fees for insurances vary based on your individual plan. Fees **do not apply** to patients with Medicaid or Peachcare.

Dr. Kate Avinger

| | |
|---|---|
| Initial Consultation: | $130 for 1-hour therapy consult |
| Psychological Evaluations: | $130 per hour |
| Psychotherapy: | $130 per 45-min session |
| Court Consultations: | $200 per hour ($800 retainer) |

(depositions, expert witness, court appearances, travel)

| | |
|---|---|
| Missed Appointments: | $50 per session |
| Late Cancellations: | $50 per session |

(cancellations must be called in at least 24 hours in advance)

*Minimum $200 payment must be made before any test is administered, and evaluations must be paid in full before any court appearances and before any testing results will be released by this office.

**I understand the above stated fees and policy.**

_____ _____

Signature of Client (or parent/guardian of minor) Date

# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

I hereby request and authorize: **Dr. Kate Avinger, Psy. D., P.C.**
485 Huntington Rd, Suite 201
Athens, GA 30606
Phone: (706) 546-8440 Fax: (706) 546-8456

To obtain from and release to: 1._____

2._____

3._____

The following types of information from my records and/or specific portions thereof:

_____ All records

_____ Exclusions

for the purposes of: _____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my consent. I understand this authorization includes release of all medical records including Human Immunodeficiency Virus records, Psychiatric, Drug/Alcohol Abuse records Venereal Disease and any other statutory protected disease records. This authorization and consent will remain in effect until I revoke this authorization and consent. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance herof.

Signature of Patient or Legal Guardian: _____

Date: _____

**CONSENT TO RECEIVE PSYCHOLOGICAL SEVICES;**
**CONFIDENTIALITY STATEMENT;**
**& PAYMENT AGREEMENT**

Minor Client Form-Child's Name:_____

I, _____, understand that counseling or psychotherapy or psychological testing has potential risks as well as potential benefits. I understand that the risks may include, for example, uncomfortable levels of unpleasant emotions and hat individuals receiving therapy may feel worse, emotionally, before they begin to feel better.

I understand that all information disclosed to my child in therapy or during psychological testing is maintained in strict confidence and that documents pertaining to my child's treatment will not be released to other parties except when mandated by law. I understand that if the therapist has reason to believe that a child or elderly person has been abused or neglected, the therapist is legally required to file a report with the appropriate authorities. I understand that if my child expresses serious intent to physically harm him/herself or another person, then a report to appropriate individuals will be required. I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my child's confidentiality. I further understand that all testing and therapy sessions may be videotaped, and the videotape recordings will be maintained to the same degree of confidentiality detailed above, as well as being subject to the same conditions under which confidentiality cannot be maintained as mandated by law.

It is my expectation that I will be made aware of my child's progress in non-specific terms, but that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

I understand that that payment is due at the time services are delivered. I understand that psychological testing reports will not be released until payment for evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those in the event that my child fails to show for an appointment or cancellation of an appointment with less than twenty-four hours notice.

I understand that Dr. Kate Avinger, is a clinical psychologist in independent practice.

I also acknowledge that I have read and understand the HIPPA Georgia Notice Form.

My signature below indicates that I have read, been advised of, and understand the above information and that I give consent for my child to receive psychological services under these conditions.

Signature of Parent or Legal Guardian:_____ Date:_____

**Kate Avinger, Psy. D., P.C.**
**Licensed Psychologist (GA #3056)**
485 Huntington Rd, Suite 201
Athens, GA 30606
Phone: (706) 546-8440 Fax: (706) 546-8456

## GEORGIA NOTICE SIGNATURE PAGE

My signature acknowledges that I have read and received a copy of the **Georgia HIPPA Notice.** The HIPPA notice details the policies and practices that protect the privacy of my personal health information. I agree to the terms and conditions described herein. I understand that I may ask questions and discuss any concerns that I might have regarding these policies and practices with Kate Avinger, Psy.D., P.C.

_____ _____

Patient (or Guardian) Signature Date

_____

Patient's Printed Name

**Kate Avinger, Psy.D., P.C.**
**Licensed Psychologist (GA #3056)**

## GEORGIA NOTICE FORM

### Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. 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 operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health 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 instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. 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 an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### III. 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 that belief to the appropriate authority.
- *Adult and Domestic Abuse* – 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 that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of an inquiry by the Georgia Board of Psychological 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 a request is made about the professional services I provided you or the records thereof, 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 where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If I determine, 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 to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. Patient's Rights and Psychologist's Duties

Patient'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 Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. (For example, 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 Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request.

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 procedures, I will notify you at the mailing address you provided.

## V. Questions and Complaints

- If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.
- If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to me.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
- You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.
- 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 mailing it to you at the address you provided.