Mary Elizabeth Trent, Psy.D.
Licensed Psychologist (GA 2773)
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. Mary Elizabeth Trent 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. 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. I agree to pay all legal fees, including preparation, travel, and expert testimony fees if Dr. Trent is called upon to appear in a legal proceeding. My fees for legal proceedings are $250 per hour, with a four hour minimum, which must be paid at least 24 hours in advance.

_____ _____

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. 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. Mary Elizabeth Trent

Initial Consultation:	$150 for 1-hour therapy consult
Psychological Evaluations:	$250 per hour
Psychotherapy:	$130 per 45-min session
Court Consultations:	$250 per hour (4 hour minimum)

(depositions, expert witness, court appearances, travel)

Missed Appointments:	$130 per session
Late Cancellations:	$130 per session

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

*Payment for 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

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Informed Consent for Treatment

Patients Name: _____

Date: _____

I, _____ (name of patient/guardian), agree and consent to participate in behavioral health care services offered and provided at the hand of/by Dr. Mary Elizabeth Trent. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to perform within: (1) scope of the provider's license, certification, and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

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

I understand that all information disclosed by either myself or child in therapy or during psychological testing is maintained in strict confidence and that documents pertaining to treatment will not be released to other parties except when mandated by law. I understand that is the therapist has a reason to believe that a child or elderly person has been abused or neglected, and then the therapist is legally required to file a report with the appropriate authorities. I understand that if I or my child express serious intent to physically harm my/themselves or another person, then a report to appropriate individuals will be required. I further understand that there may be conditions (such as court order) that may place limits on the therapist's legal ability to maintain mine or my child's confidentiality.

I understand that Dr. Mary Elizabeth Trent is a clinical psychologist in independent practice.

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

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

Signature: _____

Date: _____

Relationship to Patient (if applicable):

_____

AUTHORIZATION TO REALEASE INFORAMTION

FOR

COURT TESTIMONY

I, _____, hereby authorize Mary Elizabeth Trent, Psy.D. to provide expert testimony regarding *(circle one)* me/my child's *(name)*_____*(date of birth)*_____ case in a court of law, including all depositions, other trail or hearing related situation, or any court or litigation administrative needs. I grant Dr. Trent permission to disclose any and all information regarding my evaluation or treatment with no exceptions, including but not limited to psychological testing results, information regarding therapy, and psychological testing raw data. In doing so, I waive all rights to confidentiality.

I understand the need for and the implications of this disclosure of information and this authorization is being made voluntarily on my part. I understand that I may revoke this release in writing at any time except the extent that action based on this consent has already been taken.

I understand should Dr. Trent be required to attend any court hearings, her hourly fee is $250 an hour for a minimum of four hours. I understand court costs are to be paid 24 hours in advance.

_____ _____

Date Signature of Client

OR

_____ _____

Date Signature of Parent/Legal Guardian

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ATTENDANCE POLICY

I value all of my clients and stay committed to providing individual and focused attention on their current situation. All appointments are scheduled to allow for the maximum clinical attention during each session. Due to a large number of individuals seeking assistance and limited time slots, it is important that clients keep all appointments.

Individual therapy appointments can vary in length from approximately 20 to 55 minutes with the amount of time geared to provide the most efficient and comprehensive service. Please ask Dr. Trent if you wish to discuss treatment length and frequency of appointments. If you fail to attend an appointment and/or cancel less than 24 hours in advance, you risk cancellation of all future appointments. If this occurs, you will only be allowed to schedule one appointment at a time. The second violation of this policy can result in removal from the schedule and a referral to another mental health provider.

If you do not keep any appointments scheduled within a 45-day period, treatment will be terminated and your therapeutic relationship with Dr. Mary Elizabeth Trent will have ended.

The above policy was developed to help provide the highest level of service and scheduling flexibility to all clients.

Your signature below indicates that you have read, been advised of, and understand the above information and that you consent to receive psychological services under these conditions.

_____ _____

Signature of Client or Responsible Party Date

Mary Elizabeth Trent, Psy.D.
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Authorization to Disclose Protected Health Information

Communication between your behavioral health provider(s) and other relevant parties (i.e., primary care physician, school personnel) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with other parties. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1: The Patient

Full Patient Name: _____
Date of Birth: (MM/DD/YYYY) _____
Phone Number: _____
Insurance Company _____
Member/Subscriber Number from ID Card: _____

I hereby authorize the disclosure of protected health information about the individual named above.
I am __ the individual named above
__ a personal representative because the patient is a minor, incapacitated, or deceased

Section 2: The following represents authorization for the release of information between Dr. Mary Elizabeth Trent, Psy.D. and those parties identified by the patient (or legal guardian) in the list below. This consent allows for Dr. Trent to <u>provide</u> information to individuals and/or agencies listed, and for Dr. Trent to <u>receive</u> information from these individuals and/or agencies.

Name of Authorization 1:_____ Phone number:_____
Name of Authorization 2:_____ Phone number:_____
Name of Authorization 3:_____ Phone number:_____

<u>Authorization for Primary Care Physician</u>:

Name of Primary Care Physician:_____ Phone number:_____
Name of any other Physicians:_____ Phone number:_____

Section 4: What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5: The Purpose of the Disclosure

To release (and receive) behavioral health evaluation/intervention information with the authorized party to ensure quality and coordination of care.

Section 6: The Expiration Date of Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7: Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8: Signature of Personal Representative (Signature of Guardian – if applicable)

Signature: _____ Date:_____

Relationship to the individual: _____

Section 9: Signature of the Individual (If Patient is an adult and his/her own legal guardian)

Signature: _____ Date: _____

Dr. Mary E. Trent, Psy.D.

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 such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my 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 purposed 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 as 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 and inquire 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.