

AMY D. SIMONS, M.ED., LPC

Today's Date: _____

PATIENT INFORMATION:

First Name: _____ Last: _____ MI. ____

Address: _____
Street City State Zip

Home Phone () _____ Wk Phone: () _____ Cell () _____

Social Security No. : _____ Sex: M ____ F ____

Date of Birth: _____ Age: _____ Marital Status: S ____ M ____ D ____

Email: _____

Family Physician: (Name, Address, & Phone): _____

Place of Employment _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Social Security No. _____ Work Phone: _____

If Patient is a Minor:

Parent/Legal Guardian Name: _____

Social Security No.: _____ Date of Birth: _____

Address: _____
Street City State Zip

Place of Employment: _____ Work Phone: _____

Employer's Address: _____
Street City State Zip

3633 Wheeler Rd. Suite 100

EMAIL AND TEXT MESSAGING CONSENT FORM

I, _____ authorize _____
(Patient printed name) (Therapist name)

to send automated appointment reminder email and/or text messages to me. I understand my Therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated and does accept reply emails/texts and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at 706-364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24 business-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

Contact by text messages:

- ☐ I **DO** wish to have this contact at the following phone number:

- ☐ I **DO NOT** wish to have this contact.

Contact by email:

- ☐ I **DO** wish to have this contact at the following email address:

- ☐ I **DO NOT** wish to have this contact.

(Patient/Custodial Parent/Legal Guardian)

(Date of Signature)

AMY D. SIMONS, M.ED., LPC

Insurance Information:

Primary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Employer: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Employer: _____

Relationship to Patient: _____ SS#: _____

Assignment of Insurance Benefits

For the purpose of paying all or part of the fees owed to Amy D. Simons, LPC for the services which have or will be rendered to the above patient, the undersigned hereby irrevocably assigns any insurance payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy, but only to the extent necessary to pay Amy D. Simons, LPC, as a result of rendering services to the above mentioned patient whose liability will be reduced by the amount of benefit payments received hereunder. Undersigned understands that the nature of the patient's disability may be such that no benefit payments will be payable under the policy specified above. Any fees owed by the undersigned under the terms of this agreement shall be paid in full within thirty days after billing agency unless prior arrangements have been made in writing with Amy D. Simons, LPC.

Signature (Patient/Custodial Parent/Legal Guardian)

Date

AMY D. SIMONS, M.ED., LPC

Consent for Disclosure of Information to Third Party Payers (Entities that pay your claims):

The undersigned authorizes Amy D. Simons, LPC to release all patient information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being evaluated and treated, to the insurance company, the third party payer, or its representatives.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company or third party payer.

The undersigned understands that the information obtained by use of this "Authorization" may be used by the above mentioned insurance company or third party payer to determine eligibility for benefits under an existing policy, and further understands that information obtained by such insurance company or third party payer shall not be released to any other person unless the undersigned so authorizes.

The undersigned acknowledges that he/she may request to receive a copy of this Authorization for disclosure of information to third party payers, and that he/she may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon.

The undersigned further acknowledges that this Authorization shall be valid during the pendency of these claims.

Signature (Patient/Custodial Parent/Legal Guardian)

Date

*****IMPORTANT INSURANCE INFORMATION*****

We do not guarantee insurance benefits or insurance payments. We also do not guarantee that a provider is in network for any patient's plan. We request all patients to contact their individual insurance company to verify benefits and provider network status before their appointment.

Please sign acknowledgement of this information.

Signature

Date

3633 Wheeler Rd. Suite 100

Phone: (706)364-0252

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Fax: (706)364-0269

Billing Procedures

Appointments must be canceled at least 24 business hours prior to the scheduled appointment or you will be charged a 'no-show' fee of \$75.00.

Insurance will be filed for your appointments after the office has verified insurance coverage.

Insurance deductibles and co-payments must be met at the time of service.

Insurance laws have been enacted that forbid fee altering for services. If you have hardship needs, please discuss this with me during our first session.

Statements are mailed on a monthly basis.

I accept checks, cash, debit cards, and credit cards, Visa and MasterCard, as forms of payment.

Please direct any concerns or questions to either myself or the receptionist at (706) 364-0252.

Acknowledgement of Billing Procedures:

Please sign to indicate that you have read and understand my billing policies. If you do not understand, please inform me during our first session.

Patient/Custodial Parent/Legal Guardian

Date

AMY D. SIMONS, M.ED., LPC

For Your Information:

The following information is provided to help you understand and to answer questions you may have about therapy fees, payment and confidentiality. Please feel free to discuss any of these areas in greater depth with me.

Benefits and Risks:

Psychotherapy is a means of helping you understand yourself on a deeper level and to learn to deal more effectively with issues/problems. It can be an exciting as well as a painful process. There may be some things that happen to you that are unpleasant due to the therapeutic process. You may feel worse before you begin to feel better. Initial sessions will focus on providing coping skills to help you deal more effectively with the painful times. After psychotherapy, people often make changes in their lives. For example, they may modify some of their emotional responses, ways of thinking, and behaviors. They may make changes in their marriage or other significant relationships such as with parents, children, or relatives and friends. They may also make changes in their jobs. We will discuss the changes you anticipate as we go along. Therapy is a collaborative effort between the two of us. I cannot guarantee or promise any specific outcomes.

Costs:

Sessions are generally 45 to 50 minutes in length; however, longer sessions may be arranged. The sessions typically start on the hour and the cost for each session is \$125.00 unless there have been prior arrangements made in writing by me. There is no provision for sliding scale fees due to the recent change in laws precipitated by insurance companies. If you wish to extend your session, you must notify me prior to that session and we will attempt to work that out with your insurance company. Additional session time is charged at the rate of \$47.50 per half hour. Please read the sheet on **Billing Procedures** for further information regarding insurance and cancellation policy.

Length of Treatment:

This depends in part on your specific needs and abilities, the goals we set together, and the involvement of your insurance company. Many Managed Care Organizations now limit psychotherapy to a maximum of 20 sessions per year, some companies less. It is important that you know what your insurance company allows and that this be managed wisely. You have the right to terminate therapy at any time you choose. I would hope that you would allow me to participate in the termination decision rather than just disappearing as this deprives us both of the opportunity for feedback and closure. In addition, the insurance companies often require a discharge summary.

Confidentiality:

I treat confidentiality very seriously. No information about you, including the fact that you are here, can be released without your written consent. The only way your records or any information in your records will be released to a third party is if you assign them privilege to these materials. Progress notes are privileged and belong to me. I do not release them. I will provide a summary of progress. Please understand: there are some limits to this confidentiality. If your therapy is covered by insurance, they may request information about your condition and treatment. If your mental health benefits are handled by a managed care company, they will usually require periodic detailed information in order to authorize sessions. There is no confidentiality between myself and the insurance/ managed care company. Once the information leaves my office I am no

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longer responsible for the confidentiality of your records. Please – speak with me before you sign for someone else to obtain your records. If a collections agency must be used, they will receive only your name, address, and amount owed.

For clients under eighteen years of age, the law allows your parent/guardian access to information about your counseling with me. It is my practice to request your parent/guardian agree to receive only general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Emergency Procedure:

If you have an emergency during the day, please telephone the office, inform them that this is an emergency and I will call you as soon as I am free between client sessions. This contact will necessarily be brief and will be used to determine a course of action only. If you are in need of emergency assistance after hours, please call the main office number and you will be given instructions. If the emergency is critical and you are unable to reach me in a timely manner, then it is your responsibility to telephone 911 or have someone drive you to the emergency room designated by your insurance company. When I am out of town or otherwise unavailable, I will be using the services of a colleague to handle emergency situations. Telephone calls that are not an emergency are usually returned after hours or at the latest by the following morning. Please leave a day and evening number where you can be reached. Please inform me if you are already being followed by a psychiatrist. A psychiatrist or other M. D. is the only professional who can prescribe medications or admit you to the hospital.

Alternative Treatment:

There are occasions in which there is not a good “therapist-patient” fit. If this becomes the case, I will gladly offer you a list of referrals to other professionals in the area. I am in support of your treatment and want this experience to be a positive one for you, whether you are working with me or someone else.

Patient Responsibility:

The following are your responsibilities as a patient: Your time belongs to you and the next hour is dedicated to the next patient. If you are late for your appointment, then you will miss out on your full time. If I am late for your session, I will make the time up at the end of the hour in order to ensure you have your full session time. Please honor the 24 business hour cancellation notice policy so that the time may be utilized by someone else and you are not billed for an unused hour. You are expected to pay your bill as I have financial obligations to my office, my staff, my family and myself. Talk with me if you are having difficulty with this. Please inform me if you decide to discontinue counseling as many insurance companies require a discharge summary.

Information: The client must provide true, accurate, and complete information.

Instructions: The client must follow instructions for treatment. The client should understand the consequences of not doing so, and if unable to comply, must inform the staff or me so that efforts can be made to help.

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Refusal of Treatment: The client and family are responsible for the outcomes if they do not follow the medical plan of treatment and discontinue treatment against advice.

Respect and Consideration: Clients and family must show consideration for other clients and staff by helping to control noise and behaviors in the waiting room. **Cell phones are to be turned off in the waiting room.** You may step outside to use your cell phone. Clients and family must respect the property and privacy of others and the organization.

Obligations: The client must keep appointments and fulfill financial obligations for their diagnostic and therapeutic services.

Behavior: The client must abide by the rules and regulations of my office.

Legal Issues:

Georgia and South Carolina law requires that child abuse be reported to the Department of Family and Children's Services (GA) or Department of Social Services (SC). I am also required by law to take responsible action to preserve life. Confidentiality will necessarily be violated to the extent necessary to ensure you are kept safe until you are able to keep yourself safe.

Not all services are a covered benefit in all insurance plans. **Patients are expected to pay for any part of charges not covered by insurance.** Unless prohibited by contract, patients will be billed for any unforeseen account balances after insurance has paid. A charge of \$25.00 will be assessed on all returned personal checks. Should your account be turned over to a collection agency, you will be responsible for collection fees, attorney fees, and court costs. If temporary financial problems affecting timely payment of your account should arise, we encourage you to **contact us promptly for assistance in management of your account.**

Audio / Visual Recording:

There is to be no use of any type of visual or auditory recording devices at any time without the knowledge and consent of all parties present.

Cancellation/No Show Policy:

You are expected to remember your appointments whether or not our office staff is able to contact you with a reminder call. Appointments must be cancelled at least 24 business hours prior to the scheduled time or you will be charged. If an emergency prohibits you from the 24 hours business notice, this should be the exception rather than the rule. You may be required to provide written documentation of the emergency to prevent from being billed.

Signature: _____ Date: _____

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Client Information and Informed Consent for Telemental Health Treatment

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

Additional Points for Client Understanding:

- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand mental health is performed over a secure a communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
- I understand that telemental health sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
- I understand I am responsible for creating a safe, confidential space during sessions and I will engage in sessions in a private location where I cannot be heard or seen by others.
- I understand I am responsible for logging out or hanging up once sessions are complete.
- I understand you may contact me from a blocked number to avoid others knowing we have connected.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
- I understand that I am required to provide an emergency contact (see below) in case of an emergency.
- I understand that telemental health-based services may not be appropriate for everyone seeking therapy. In person therapy may deemed necessary by my therapist.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet, or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.
- I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
- I understand that email is not an appropriate means of communicating with my therapist in the case of emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the

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case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, payments, insurance questions, or supplying other information.

- I understand that it is my responsibility to call and make payment for any balance due at the conclusion of my telehealth session.

Emergency Contact Name: _____ **Emergency Contact Number:** _____

CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment, please follow the same procedure you already agreed to in the *Client Consent for Counseling* documents. **As a reminder, cancellations should be made within 24 hours of your scheduled session time, unless you have a same day emergency arise.** Please call and inform our office of any same day emergencies. **If cancellation is not made within 24 business hours, I reserve the right to charge a \$75 fee in the same way a fee is charged for missing or late cancelling in-person sessions.**

PAYMENT FOR SERVICES

As with your in-person sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors*. Not all mental health services are a covered benefit in all insurance plans. If you are unsure of coverage, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.).** Billing processes are the same for telemental health services as with in office visits, as outlined in the *Client Consent for Counseling* document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **Please call the office to make a payment by at the conclusion of your session.**

CONSENT

I consent to engaging in telemental health as part of my treatment with Amy Simons, LPC. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Name of Patient (Print)	Email (Print)	Cell Phone
_____	_____	_____

Signature of Patient	Date
_____	_____

Name of Legal Guardian [if patient under 18] (Print)	Signature of Legal Guardian	Date
_____	_____	_____

INFORMED CONSENT FOR IN-PERSON SERVICES AND COVID

Decision to Meet Face-to-Face

There may be a need to meet in person for some or all sessions. If there is a resurgence of COVID or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for both of our well-being.

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If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our staff, our families, and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each point below to indicate that you understand and agree to these actions:

- Face masks are currently optional. You may wear a mask in the office if you choose. _____
- The waiting room should be limited to patients being seen for therapy sessions. Minor patients or patients needing physical assistance may bring 1 person with them into the waiting room. Please contact the office if this creates a problem for you. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately inform me/office staff. _____
- If you or a resident of your home tests positive for the infection or have been symptomatic from COVID within the last 10 days, you will immediately let me/office staff know and we will then [begin] resume treatment via telehealth. _____
- I understand that my therapist cannot be held responsible for any exposure risks outside of the therapy office in other parts of the building or the parking lot. _____

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

If You or I Are Sick

You understand that I am committed to keeping you, me, my staff, and our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff, believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I, or my staff, test positive for the coronavirus and may have exposed you, I will notify you so that you can take appropriate precautions.

Informed Consent

This agreement supplements the general informed consent/business agreement.

Your signature below shows that you agree to these terms and conditions.

Patient

Date

3633 Wheeler Rd. Suite 100

AMY D. SIMONS, M.ED., LPC

INFORMATION FOR COUPLES/MARRIAGE/FAMILY COUNSELING

IDENTIFIED PATIENT SAFEGUARDS

In accordance with the compliancy of the Health Insurance Portability and Accountability Act (HIPAA), this practice has placed certain safeguards to protect the health information of the identified patient. The following safeguards apply to those receiving services for couples, marriage, or family counseling in this practice:

- There is only one identified patient 18 years of age or over (regardless of who is the policy holder, relationship to the patient, or who makes payments). Only the identified patient has rights to their protected health information.
- Only the identified patient can schedule, cancel, reschedule, or inquire about any appointments.
- Only the identified patient can have individual sessions. Individual sessions for any other party must have the approval of the identified patient and the therapist.
- The identified patient is ultimately responsible for all payments, regardless of the source of those payments. Billing issues must also be handled by the identified patient.
- The identified patient has the option to complete a release of information form, granting another party permission to schedule, cancel, reschedule, or inquire about appointments. This form is also required for the release of billing related questions.

By signing this form, you acknowledge that you have read, understand, and will abide by these safeguards.

Patient

Date

Spouse/Other Party

Date

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AMY D. SIMONS, M.ED., LPC

INFORMED CONSENT AND TREATMENT AUTHORIZATION:

By signing this Patient Informed Consent and Authorization as the Patient or Guardian of said Patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment and services, from Amy D. Simons, LPC, for me (or my child if said child is the patient).

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my/their health insurance. Deductibles and co-payments will be made at the time services are rendered.

Signature

Date

In Case of Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Whom may we thank for referring you to us? (Name and Address if Known)

AMY D. SIMONS, M.ED., LPC

****WOULD YOU LIKE INFORMATION RELEASED TO YOUR PRIMARY CARE PHYSICIAN?**

YES_____ (COMPLETE ALL INFORMATION BELOW – SIGN & DATE)

NO_____ (PLEASE SIGN & DATE AT THE BOTTOM)**

Client:_____ Birthdate:_____

I, _____, authorize Amy D. Simons, M.ED., LPC and my primary care physician,

Dr._____

Phone#_____ fax#_____

Address_____

to exchange information regarding my mental health and/or substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care and/or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for 12 months from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my primary care physician.

Signature:_____ Date:_____