Germantown Psychological Associates, P.C.
7516 Enterprise Avenue, Suite 1
Germantown, TN 38138

Tel: 901-755-5802
Fax: 901-757-2249

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Registration Information

Patient Legal Name: _____ Age _____ Sex: M F

[If patient goes by a different first name: _____]

Parent Name (if patient is a minor): _____

Home Address _____Ph#_____Cell# _____

City _____ State _____ Zip _____ E-Mail _____

Work Address _____ Phone _____

City _____ State _____ Zip _____

Daytime number where you may be reached regarding appointments _____

Patient's Date of Birth _____/_____/_____ SS# _____

Insured/Responsible Party (if other than patient) _____

Insured's Relation to Patient _____ Insured's Date of Birth ____/____/_____

Insurance Company _____

Insurance Company's Address _____

Insured's Place of Employment _____ I.D., Policy, or Group Number _____

Provider of Previous Treatment _____

Referred by _____

If the patient is less than 18 years of age, I attest that I am the legal guardian and have authority to initiate treatment for my child.

Yes ☐ No ☐ Signature _____

 Patient or Responsible Party Initials ☐

PATIENT INFORMATION

The following information is being provided so that you will have an understanding of the conditions of your therapy. Please read this carefully, and feel free to ask questions about anything that seems unclear. Your signature indicates your consent and agreement to these conditions.

TYPE OF PRACTICE

Germantown Psychological Associates, P.C. (GPA) offers outpatient therapy and psychological services that include, but are not limited to: evaluation, individual and group therapy, marital and couples therapy, family therapy, divorce counseling, adolescent and child/pediatric psychology, psychological testing, health psychology, biofeedback training, and stress management training. The decision as to which type of therapy to use will be decided jointly with you after an initial assessment. Should services that we do not provide appear indicated, we will be glad to suggest other options and make referrals for you.

Practitioners do not provide any medication or perform any medical treatments. We maintain consulting relationships with physician colleagues in the event that medical treatment/evaluation is indicated as an adjunct to therapy. In the event that inpatient treatment appears indicated, we will assist you with an appropriate referral with your permission and signed consent.

PSYCHOTHERAPY

Psychotherapy is designed to help people increase their understanding and awareness of problem areas and to learn more effective methods of dealing with these issues. There are potential risks as well as potential benefits. Psychotherapy may involve the risk of remembering unpleasant events and experiencing intense emotions. People sometimes report feeling worse before feeling better, and in personal relationships (e.g. marital relationships) it is possible for one party to develop or change in such a way as to grow apart from his or her partner, and thus weaken or dissolve the relationship.

The potential benefit from psychotherapy may be the ability to handle or cope with the stress and problems in your life and experience more satisfaction from relationships. You may also gain a better understanding of your personal goals and values, leading to greater maturity and personal growth, increased general satisfaction with life, and an improved sense of "well-being".

Therapy is an endeavor that requires much effort, and though we provide our time and our professional knowledge and services, we cannot promise or guarantee specific results. We feel strongly about providing you with quality care and consequently we will regularly review with you your goals and progress in therapy. At any time, you have the right to decide not to receive our services and to end our work together. There is no moral, legal, or financial obligation other than to pay for services already rendered. We do encourage you to discuss your decision to terminate with your therapist. If you wish, we can provide you with the names of other mental health professionals.

CONFIDENTIALITY

Within the limitations discussed below, **all information revealed by you during our professional relationship will be kept confidential and WILL NOT be released to anyone without your WRITTEN CONSENT.** However, under the following circumstances, we may be required to breach confidentiality: 1) if you present a danger to yourself or to others, which includes communicable diseases that can be life-threatening to others; 2) if we have reason to believe that child abuse/neglect or domestic violence has occurred or is present; 3) if treatment is ordered by or under supervision of the courts; or 4) if a legitimate court order is issued.

Additionally, insurance companies and managed health care organizations representing third-party payers often require you to consent to release records and/or information (including, but not limited to diagnosis, type of services rendered, dates of service, treatment plans, and other related confidential information) to them as a condition for reimbursement. Your signature(s) below indicate(s) your permission to release information requested by your insurance company or its representative. When such information is revealed to insurance companies or managed health care organizations, we cannot control how the material is treated. Information revealed in marital therapy is also protected by privileged communication, which requires permission of both to waive. In order to

provide for consultation and emergency coverage, the psychologists/therapists affiliated with Germantown Psychological Associates, P.C. do discuss patients among themselves unless you specify otherwise. If because of nonpayment of your bill we pursue legal remedies, the financial aspects of your relationship with us will not be considered confidential.

APPOINTMENTS

Patients are seen by appointment only. **If a conflict arises that will cause you to miss a scheduled appointment, please notify our office. At a minimum, 24 hours notice is needed to fill a cancelled appointment time. If you do not give us 24 hours notice, a missed appointment fee will be charged.** In the event of extremely bad weather (e.g., snow and ice), it is advisable to call our office before you leave home to determine if the office is open.

TELEPHONE CALLS

We attempt to be reasonably available for telephone calls, but when in session with patients, we cannot be interrupted for incoming calls. We can usually be reached through our office or our after hours phone service in case of emergencies. However, the telephone is not the manner in which to deal with therapy issues, and **telephone consultations exceeding five minutes will be charged at the normal therapy fees and are not be covered by your insurance.**

FINANCIAL CONSIDERATIONS

SERVICES USUALLY COVERED BY INSURANCE

Standard operating hours for Germantown Psychological Associates, P.C. are 9:00 a.m. to 5:00 p.m. Monday through Friday. Sessions conducted outside of these designated time periods may have after-hour charges.

Psychological testing is often requested by the clinician in order to facilitate treatment planning and progress in therapy. Testing fees are based on time required for assessment, tests administered, interpretation, and report writing. The testing fees do not cover subsequent sessions to review the results and/or discuss intervention strategies. When psychological testing is requested, a separate appointment will be made for you by the office. **Testing fees must be paid in full prior to the evaluation.**

SERVICES NOT COVERED BY INSURANCE

Should a request be made of your clinician that he/she become involved in legal matters (e.g., giving testimony, deposition, etc.), the fee for such activity is $250 per hour for preparation and review of materials and then $400 per hour for all other time involved, to include, but not limited to, travel time, court time, and any other time involved. A retainer fee based on the estimated time involved will be charged, to be paid 4 business day in advance, with the minimum including $250 preparation along with $800 for two hours of deposition/testimony for a total of $1,050. If the deposition or court hearing is cancelled less than two business days before the scheduled time, the minimum charge of $1,050 will be forfeited. **NOTE:** Clinical work for the specific purpose of involvement in civil cases, custody evaluations, mediation and criminal cases may require a separate agreement and fee schedule different from the above.

Letters, treatment summaries, copies of treatment records, and psychological testing reports are sometimes generated and released to patients, other professionals and insurance companies. Tennessee law and the ethical principles promulgated by the American Psychological Association govern the release of such written communication. Appropriate releases must be signed.

A written request form for the release of information is available from the receptionist and is required to begin the process of obtaining information. Written requests help ensure that information released is what was requested and that it is sent to the appropriate individual/agency. **The standard turn-around time for request for written information is ten (10) business days.** Urgent or "emergency" requests shall incur a surcharge to be paid before the information is released.

A separate fee will be assessed for generating letters, treatment summaries, or other written communications outside the regular therapy session. These charges, as well as surcharges for "Urgent" requests, will vary depending on the complexity of and time required to complete the request.

Due to the cost of transfer of old records into storage after being inactive twelve months, along with maintenance of stored records, any requests for copies of records and treatment after this time period will incur a specific fee related to storage and retrieval. Arrangements can be made to pick up requested records. An additional fee for FedEx delivery will be charged if the individual requests that the records be delivered.

BILLING

As a courtesy to our patients, our office will file insurance claims for you. **However, due to the complexity of insurance and billing, our office will not "back file" any insurance claims.** Patients who have health care insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. **Regardless of the action of your insurance company, you are responsible for your bill. Co-payments are due at the time of service. GPA, PC does not carry balances on accounts.**

Our Responsibility to Report Non-Compliance: Under many managed care contracts, it is the provider's obligation to report patients who refuse to pay co-pays and deductibles at the time of service or patients who repeatedly "no show" for appointments. We have reserved the right to take this action. Please understand that if you are reported, you could lose your insurance benefits. You can contact your Human Resources department or your insurance company for further information on this matter.

Though we make every effort to keep costs down, fees may change over the course of your treatment. You will be responsible for the increased fees. For individuals who are not covered by health care insurance, the full balance is due and payable at the time of service. There will be a billing fee of $5 per month after 60 days. There will be a $30 service charge on all returned checks. If this account is litigated or turned over to an attorney for collection by suit or otherwise, the patient (or responsible party undersigned) agrees to pay all costs of collection and litigation, together with a reasonable attorney's fee.

PATIENT AGREEMENT

Having read the foregoing information fully and completely, I have discussed any questions I had about the information with my therapist or an employee of Germantown Psychological Associates, P.C. and I understand the information fully with respect to the proposed treatment. I understand and accept the risks inherent in the course of therapy proposed for me.

I have familiarized myself with the fees and charges for services provided by Germantown Psychological Associates, P.C. I understand and agree that the services to be rendered will be charged to me and not to any insurance company or third-party payer. I understand that Germantown Psychological Associates, P.C. will bill me for professional services rendered in accordance with the information set out above, and I acknowledge my responsibility for payment for such services; moreover, I understand that I am responsible for all costs of collection and litigation together with a reasonable attorney's fee if the charges for services rendered to me must be collected by an action at law.

I consent and agree that Germantown Psychological Associates, P.C. may release such information as may be required by my insurance company or managed health care organization for payment for services rendered for me. I agree to hold Germantown Psychological Associates, P.C. harmless for any injury or claim for damages arising from release of records or information as required by my insurance company or managed health care organization.

Patient (s) _____ Date _____

Responsible Party/Guardian _____ Date _____

Emergency Contact Information

Please identify an individual below who you give us permission to contact in the event of an emergency with you or your child:

Name:_____Phone:_____Relationship:_____

This Registration Form was reviewed by:
_____ [Employee]

Patient or Responsible Party Initials ☐