New Client Information
Dr. Peeler

Date:____

Name:____

Address:____

____

Social Security Number:____

Phone numbers: Home:____

Business:____

Cell:____

May any of these numbers be used to contact you? **YES** or **NO** (please circle). If "No" is your response which numbers are not to be used?

____

***Please be advised that if you have caller ID, calls from this office may be identified on you caller ID. If you prefer calls not to be identified as originating from this office, you will have to disable your caller ID

Date of Birth:____

Occupation:____

Marital Status____

Spouses Name:____

Spouses Occupation: ______________________________Spouses D.O.B.__________

Name of Referral person or agency:____

(May the referring person or entity be contacted)? **YES** or **NO**.

Previous Psychotherapy? : **YES** or **NO** (please circle)

If "yes', give brief information regarding dates, name of previous therapist(s). Please include reasons for previous therapy.

____
____
____
____

Previous psychiatric hospitals? **YES** or **NO** (please circle) If "yes" give brief information including dates, location, reasons hospitalization, name(s) of treating psychiatrist or psychologist

____
____
____

Reason for seeking psychotherapy at this time? May include symptoms you are having and/or current stressors____

____

____

____

____

How long have current issues persisted?____________________________________

____

Has anyone in your family or your family history had a mental health problem? If so, did this person(s) receive treatment? Medication ?(name of medication if you know this information)

____
____
____
____

Please List All medications that you are currently taking:____________________

____
____
____
____
____
____

Please list any medications you have previously taken for an emotional/psychological/developmental disorder. Please give dates when these medications were started and terminated.-
____
____
____
____

Are you currently or have you ever used illegal substances? **YES** or **NO**
(if "yes" please give added information such as when, how often etc.)____

____

Do you currently use alcohol? **YES** or **NO** If "yes" how much do and how do you drink? ____

Has drinking alcohol or drug use ever resulted in a legal problem?____
____

Has anyone in your family or family history had a problem with drugs or alcohol?____
____

Are you currently involved **or do you expect** to be involved in any legal actions? Including a Workman's Comp. claim, Disability Claim, Social Security benefits claim, custody evaluation or a psychological evaluation to be used for any legal purpose?

YES or **NO** (please circle) If "yes" please give a brief description____
____
____
____

Please be advised that I provide treatment for the symptoms of behavioral health conditions. I am **not** a forensic psychologist and I do **not** provide psychological evaluations for any purpose other than for psychotherapy treatment. I do not do psychological evaluations for workman's compensation, disability, SSI or any type of court related hearing.

Do you have a chronic illness or a physical condition, which affects your mood?
____
____
____
____
____

Have you had any life changes within the past two years such as divorce, moving, marriage, job loss or change, death of a loved one, dissolution of an important relationship, or other life change?

____
____
____

Please write a brief summation of major life events which have occurred in your life from childhood to present (you do not need to repeat any information which you have given in above question)

____
____
____

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

PAYMENT INFORMATION

Who is responsible for your bill?____

If you **do not** plan to use health insurance for payment of services, payment will be expected at the time of Each session. The session rate is $140.00 for a **45-50** minute session and $150.00 for a **one hour** session. Sessions that last longer than this time period will be pro-rated and additional costs will occur. The **initial** session is billed at $160.00.

If you **do** plan on using your health insurance for the services:

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they

may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Also, while I do accept insurance from some insurance companies, it will be Your responsibility to check with your insurer as to whether I am a provider on your plan. Additionally it will be your responsibility to check to see if any authorizations or pre-certifications are required, the amount of deductible which you have used, and your co-payment amount. Also, if you are allotted a specific number of visits, you will need to keep up with the number we have used as we near the limit and keep me informed as to whether we need to request additional visits. It is your insurance and you will need to know the rules. It is virtually impossible for me to stay current on all of the rules for the great variety of plans which are available to consumers. Therefore it will be your responsibility to be aware and keep me aware of any rules or changes which occur with your insurer. You are responsible for any portion of the allowable charge that your insurance company does not pay.

Health Insurance (Please fill out this information entirely)

Are you planning on using health insurance for these services? **YES** or **NO**

If you **do** plan to use health insurance for these services:

Have you checked with your carrier regarding eligibility for behavioral health benefits? **YES** Or NO. (Please circle)

Please be advised that if you have Not contacted your carrier and obtained authorization regarding eligibility for benefits, that You will be responsible for the balance on any unpaid or partially paid claims

Co-payments are expected to be paid at each session.

Health Insurance Information

Name of Carrier:____

Billing Address of Carrier (please note that the billing address for behavioral health may be different from the address for medical services):________________

____

____

Phone number information of carrier (may be different for behavioral health services) :____

____

Your policy identification number with your carrier:___________________________

____

Your policy group number with your carrier:________________________________

____

If you are Not the primary person listed on your policy please provide the name, policy identification number, and date of birth of the primary insured:

Name: ____________________________________Date of Birth:____________

Policy number: ____

What is the date of the calendar year for your insurance policy?______________

What is the deductible for your policy regarding behavioral health services?____

Have you met your deductible at this time? _________________________

****Be advised that You are responsible for any amount of your bill that goes toward your yearly deductible and is not paid by the insurer.

NOTICE FOR ALL CLIENTS, REGARDLESS OF PAYMENT ARRANGEMENTS

*****Any bills for which you are responsible, and which have not been paid in a timely manner, may be forwarded to a collection agency and reported to credit bureaus. This action is a legal exception to your right of confidentiality.

<u>Confidentiality:</u> You have a right to confidentiality because you are seeing a Licensed Psychologist. Please know that I will protect your confidentiality as my utmost responsibility to you.

However, there are exceptions when the right of confidentially is waived. These exceptions include any information which you divulge related to: 1. Your intent to harm others 2. to harm yourself 3. or the sexual or physical abuse of children or the elderly. Additionally is you have signed a waiver when obtaining health insurance, certain information may be shared with your insurance company.

Other than the above named exceptions, seeking therapy from a licensed psychologist provides you with strict guidelines protecting your confidentiality in the state of Georgia.

Text and Email Communication Please be aware that neither text nor email communication is privacy protected and these avenues should be limited to brief, non-clinical communication only. If you choose to engage in email or text communication you are accepting any and all risks associated with email and/or text security.

A 24 hour notice is required for all cancelled appointments or you will be responsible for the cost of the session. If I am able to fill the session time with less than 24 hour notice, you will not be charged.

Signature of client:____

Date of signature:____