For Office use:
_____

COUNSELING SERVICES ASSOCIATES, INC.
Glenn W. Small, Jr., M.Div., M.A., L.P.C.

PATIENT INFORMATION

DATE OF FIRST VISIT _____
REFERRED BY _____

PATIENT NAME _____ BIRTHDATE _____

SS# _____ ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE_____

EMPLOYER _____ BUS. PHONE _____

CELL PHONE _____

PREFERRED EMAIL ADDRESS:_____

SPOUSE'S NAME (IF APPLICABLE)_____SS#_____

EMPLOYER _____ BUS PHONE_____

RESPONSIBLE PARTY _____ HOME PHONE _____

ADDRESS & PHONE # IF DIFFERENT FROM ABOVE _____

_____

NEAREST RELATIVE OUTSIDE OF HOUSEHOULD _____

HOME PHONE _____ BUS. PHONE _____

PAYMENT/APPOINTMENT POLICY

Professional fees are based on **$150.00** for a regular one-hour counseling session. Telephone consultations in excess of 5 minutes will be charged at regular session rate. Supportive services will be charged on a time-prorated basis. Other expenses for professional services will be billed to the responsible party by prior agreement. Many insurance carriers restrict fees charged by providers; those restrictions are followed by this office.

In the event you are unable to keep your appointment, **YOU WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED FRIOR TO 24 HOURS OF YOUR SCHEDULED TIME.** Messages can be received at any hour.

Payment is expected at the **time of each session** unless prior arrangements have been made. If your preference is to make one payment each month, the total balance is due upon receipt of the monthly statement. You will be sent a monthly statement which contains all necessary information to submit to your insurance company for reimbursement; or the office will file your claims in a timely manner. For unpaid balances carried 60 days or longer, without any payment activity, an outside agency will be employed to secure the account.

INSURANCE

Although most insurance plans cover my services, there are some that do not. **It is your responsibility to check with your insurance carrier in order to make sure that you have the needed coverage.** Although we expect you to take responsibility of filing your own insurance claims, there are plans for which we must file for you. In this case, we **MUST** have all the information necessary in order to file these claims. You will need to complete the insurance information sheet in its entirety. SHOULD YOU PREFER, THE OFFICE IS WILLING TIO FILE FOR YOU.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED BY GLENN W. SMALL, JR., M.DIV., M.A. FOR THE BENEFITS OF THE ABOVE NAMED PATIENT.

_____ _____

PATIENT/GUARANTOR DATE

INFORMEND CONSENT FOR PSYCHOTHERAPY

All communications will be held in confidence except when disclosure is required by law.

Disclosure is required in cases involving physical/sexual abuse or neglect, as well as when the client presents a danger to self or others.

Note 1. Court orders have been used to gain access to client's records.
Note 2. Your insurance may have asked you to sign a waiver of confidentiality.

NOTE: THIS OFFICE IS IN COMPLIANCE WITH ALL HIPPA REGULATIONS.

EVLAUATION AND TREATMENT

If required by your insurance company, I will provide a DSM-IV diagnosis. Otherwise I will evaluate your presenting problem and tell you what treatment I recommend.

I understand and agree to these conditions.

Signed _____

INSURANCE NFORMATION

FULL NAME OF PATIENT _____ SS# _____

FULL NAME OF INSURED _____ SS# _____

INSURED DATE OF BIRTH _____ INSURED SS# _____

ADDRESS OF INURED (if different from patient): _____

_____

INSURED'S EMPLOYER (if a group plan): _____

GROUP NUMBER _____ INSURED'S ID NUMBER _____

NAME OF INSURANCE CARRIER _____

COMPLETE ADDRESS WHERE CLAIMS SHOULD BE SENT:

_____
_____
_____
_____

ADDITIONAL INFORMATION

_____
_____
_____
_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.

I AUTHORIZE PAYMENT OF MEDICAL BENEFUITS TO GLENN W. SMALL, JR., M.DIV.,M.A., FOR SERVICES PROVIDED THIS PATIENT AND FOR WHICH HE FILES INSURANCE CLAIMS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THAT PORTION OF THE CHARGE NOT PAID BY THE INSURANCE COMPANY.

_____ _____

PATIENT/INSURED DATE

HIPPA Statement

D. Request for PHI disclosures. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request in writing. The list I give you will include disclosures made in the previous sex years (the first six year period being 2003 – 2009) unless you indicate a shorter period. The list will include the date of disclosure, to whom PIH was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response in 60 days of my receipt of your request. I may deny your request in writing if, I find that: the PHI is (a) correct and complete, (b) forbidden to disclosed, (c) not part of my records, (d) written by someone other than myself. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

V. How to complain about my privacy practices. If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in section VI. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. Person to contact for information about this notice or to complain about my privacy practices.
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of Department of Health and Human Services, please contact me at: [Glenn W. Small, Jr., LPC 2300 Henderson Mill Rd., Suite 411 Atlanta, GA 30345, (770) 414-5957].

VII. Effective date of this notice
This notice went into effect on **April 14, 2003**

I acknowledge receipt of this notice

Patient Name: _____ Date: _____ Signature: _____

Patient Name: _____ Date: _____ Signature: _____

Patient Name: _____ Date: _____ Signature: _____