Dear New Patient,

Thank you for allowing us to provide you our services!

To assure the most comprehensive and efficient service we can offer, please bring the following items with you to your first appointment (* = required):

a) **Driver's License***

b) **Insurance Card (If insurance is being used)***

c) **Method of Payment (Cash, Check, Money Order, Credit [Visa, AMEX, MasterCard])***

d) **Completed Forms (Pages 3 - 8)***

e) **Completed History Intake Form Sent in Before the Day of Your Appointment***
Failure to do so can result in rescheduling or untimely delays.

f) **Papers pertaining to: Court ordered evaluations, probation, police records & subpoenas (If applicable)***

g) Previous Psychological Evaluations

h) Medical records pertaining to your visit.

i) Custodial papers

j) School Reports (past year)

We look forward to seeing you!

Sincerely,

M&M Staff

Mind&Motion
Developmental Centers of Georgia

What to Expect From Us

After your initial appoint and if testing is being pursued

- **Your proposal for testing will be submitted to your insurance for approval.**
  - Proposals will only be sent to insurance if we are providers for your insurance company. Insurance may take up to 14 days to respond to a preauthorization for testing hours. Depending on your benefits and number of hours requested, your insurance may choose only to cover a smaller part of the requested hours for testing. The remaining hours will need to be dropped or covered out-of-pocket.

- **Testing will be scheduled and completed.**
  - You will be given the results of your insurance authorization. Testing can take anywhere between 1 – 2 days depending on the size of the battery and the speed of the test taker. If your testing is to be done off medication, please make sure to be off the medications for the amount of time specified by the doctor.

- **A feedback appointment will be scheduled.**
  - The purpose of this appointment is to have the test results explained to the client. A list of recommended therapies will also be provided.

- **When do I receive my written copy of the report?**
  - A written, final copy of the report will be sent to the client between 3 – 5 weeks after the feedback appointment. You may still pursue the recommended therapies before receiving the written report.
  - We provide both personal and school versions of the reports directly to you so that you can pass them along to any party you need. Relying on us to pass reports to other parties becomes difficult due to HIPAA regulations.

- **Therapies can be scheduled with reception after the feedback appointment.**

- **For questions regarding where you stand in the process, ask for a front office manager at 678-749-7600.**

Mind&Motion
Developmental Centers of Georgia

Patient Information & Pay Agreement

Patient Information

First Name:_____ MI:____ Last Name:_____ DOB:_____ Gender:_____

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____ Email:_____

SSN:_____ Language:_____

Race: ☐Asian ☐Black or African American ☐White or Caucasian ☐Multi-Racial ☐Unknown / Not Reported

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown / Not Reported

Marital Status: ☐Single ☐Married ☐Other

Employment: ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Other

Policy Holder Information

Relationship: ☐Self ☐Parent/Guardian ☐Spouse ☐Other:_____

First Name:_____ MI:____ Last Name:_____ DOB:_____ Gender:_____

Mailing Address:_____ City:_____ State:_____ ZIP:_____

SSN: _____

Home Phone:_____ Cell Phone:_____ Email:_____

Primary Insurance:_____ Member ID:_____ Group#:_____ DOB:_____

Secondary Insurance:_____ Member ID:_____ Group#:_____ DOB:_____

Referring Provider Information

Primary Care Physician:_____ Address:_____ Phone #:_____

Referring Physician:_____ Address:_____ Phone #:_____

Emergency Contact Information

First Name:_____ Last:_____ Phone #:_____

First Name:_____ Last:_____ Phone #:_____

FEE SCHEDULE

Insurance Reimbursable Services:

Diagnostic History Interview	$270.00
Psychological/Neuropsychological Testing (per Hour)	$185.00
Psych Therapy/Consultation/qEEG Review (30 minutes)	$67.50
Psych Therapy/Consultation/qEEG Review (45 minutes)	$135.00
Psych Therapy/Consultation/qEEG Review (60 minutes)	$185.00
Feedback Appointment	$185.00
Occupational/Speech/Physical Therapy Evaluation	$350.00
Occupational/Speech/Physical Therapy (30 minutes)	$60.00
Occupational/Speech/Physical Therapy (60 minutes)	$120.00

Cash Only Services:

IEP/504/Educational Consultation (per Hour)	$120.00
Tutoring (per Hour)	$47.50
Social Skills Groups (6 weeks; 1.5 hour sessions per week)	$280.00
Handwriting Without Tears (per Hour)	$120.00
SIPT Testing	$750.00
Professional Record Review Time (per Hour)	$185.00
qEEG with Written Report	$550.00
qEEG without Written Report	$135.00
Gas Mileage Reimbursement (per Mile)	*

(*) Fee determined by current IRS reimbursement rate for travel.

The fees listed above do not represent contracted in-network reimbursement rates from insurance companies. Some screening or registration fees may apply to cash only services.

In the event that I choose to proceed with services provided out-of-pocket, or should services fail to be covered by my insurance plan/policy, I will be responsible for the full charged amount of the services listed above.

_____ _____

Signature of Financially Responsible Person(s) Date

Cancellation & No Show Policy

Dear Patient:

We strive to render excellent care to you and the rest of our patients. In order to do so, we have had to implement an appointment cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of care. Patients who are not able to keep their appointments are required to provide timely notice of cancellation prior to their appointment time. Providing the required notice gives us the opportunity to schedule patients who may need to be seen urgently or from a wait list so they may be seen sooner.

Due to the nature of our practice, **24-hour notice** is required to change your Appointments. Please call (678) 749-7600 to do so.

Patients who DO NOT provide the required notification for cancellation are subject up to a $50.00 fee that is NOT COVERED by insurance.

Multiple Cancellations or No Shows will result in dismissal from our practice.

Thank you for cooperation.

**I have read and understand the rules and regulations of this policy and the penalties incurred for failing to abide by it.*

Signature:_____ Date:_____

**In the event that I fail to provide adequate notice of a cancellation, I assume full responsibility for the cancellation / no show fee and allow the following credit card to be charged to render payment for this fee.*

Signature:_____ Date:_____

Patient Credit Card Information:

First Name:_____ Last Name:_____

Billing Address:_____

Billing City:_____ State:_____ ZIP:_____

Credit Card Type:

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Credit Card #:_____ Exp Date:_____

Authorization/Responsibility/Notification Agreement

Psychological Sciences Institute, LLC (PSI) and **Kidz Therapy Networks (KTN)** are affiliates of the office of **Mind and Motion, LLC (M&M)**. Although M&M may manage the schedules, phones, operations, and clinical aspects of the affiliation please be advised that claims may be submitted and payments will be assigned to PSI and KTN for their respective services. Please render payment to the company that appears on your invoice or statement.

We accept cash, checks, money orders, and credit card (Visa, Amex, & MasterCard) payments. Returned checks will receive an overdraft charge of $25.00 per check.

Filing an insurance claim form on your behalf does not release you of the responsibility of paying your bill in full. Although you may have a pre-authorization, this is not a guarantee of payment stated by your insurance company. Ultimately, it is the responsibility of the member to keep track of benefit limits and exclusions and pre-existing clauses on his or her policy for services as per insurance requirements and verify network status of rendering services.

I hereby assign all medical/mental health benefits to which I am entitled to Mind and Motion, LLC (M&M). This agreement shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I have read this and agree.

*_____ _____

Signature (responsible party for payment) Date

Insurance Coverage Responsibility/Terms:

I understand that whether I am an "out" or an "in-patient", professional services may or may not be covered by my medical or mental/behavioral health insurance policy. And although M&M agrees to assist in completing my insurance form, it is a convenience and a courtesy to me. However, my insurance coverage will pay according to the company terms for the services so long as I have met my deducible for the year; but, I agree that I am ultimately responsible for the payment of the established fees regardless of insurance coverage, in full, prior to testing or at the time of testing unless other arrangements have been made with a representative of the billing office of M&M. If any tests are not conducted or we are unable to complete any test, the client will be refunded toward that test with the exception of a $40.00 non-refundable fee, for electro-physiological procedures which may include but is not limited to QEEG, EEG and rEEG.

I understand that I am responsible for monitoring the continuity of coverage and will not hold M&M responsible for inaccurate information provided by my insurance company, or for decisions or changes made by my insurance company.
I have read the terms of this agreement, have had an opportunity to ask questions about the terms of the agreement, and I am of the opinion that I fully understand the terms of this agreement.

I authorize the release of any medical or other information necessary to process insurance claims for myself or concerning my minor child where applicable, and while it is expected that those to whom such information is released will hold it confidential, I agree to hold **MIND & MOTION (M&M)** harmless from violations of confidentiality arising from the release of such information by sources other than M&M where such release has not been approved by same.

_____

Signature Client/Parent/Legal Guardian/Person(s) responsible for release of information

Delinquent Accounts and Collections:

I understand that a delinquent account is any account, which is not being complied with in accordance with this written agreement. I understand that the failure to pay the fees for services may result in collection purposes (after 60 days) and should my account be turned over for collection, fees for these services can be included. If we refer collection of your account to a lawyer, who is not our employee, you will be liable for any reasonable attorney fees we incur to the extent permitted by law.

_____

Signature (Person or persons responsible for charges)

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Please note! No information will be sent to any party except to the client and/or parent or legal guardian as indicated without the explicit permission.

Patient Name: _____ Date of Birth: _____

M&M is networked with various professionals who provide supplemental services. By checking the boxes below, you are giving permission for staff members of Mind and Motion, LLC (M&M), to review information in order to expedite time in joint assessment practices and improve therapeutic efficiency.

I hereby authorize Mind and Motion, LLC

☐ **To release information to** ☐ **To obtain information from** ☐ **To communicate with**

I recognize there are additional organizations, doctors, schools, etc. that would benefit from having specific information provided to/from M&M. Therefore, I hereby authorize Mind and Motion, LLC to send/receive information to the following parties:

Name_____ Phone:_____
Email: _____ Fax: _____
Street:_____ City:_____ State:____ Zip:_____
Please send the following information (check appropriate box):
☐ Psychological Report ☐ Progress Report ☐ Treatment Summary

Name_____ Phone:_____
Email: _____ Fax: _____
Street:_____ City:_____ State:____ Zip:_____
Please send the following information (check appropriate box):
☐ Psychological Report ☐ Progress Report ☐ Treatment Summary

Name_____ Phone:_____
Email: _____ Fax: _____
Street:_____ City:_____ State:____ Zip:_____
Please send the following information (check appropriate box):
☐ Psychological Report ☐ Progress Report ☐ Treatment Summary

After giving due consideration to the extent of this release, I authorize Mind and Motion, LLC to furnish information, including photo static copies of my psychological records concerning my evaluation or treatment, to the above individual(s), organization(s) or to its agent(s), and I further agree to indemnify and hold harmless Mind and Motion, LLC from all liability that may arise from the release of the information herein requested. Any information released in response to this authorization should not be re-released to any other person(s) unless I so specifically authorize. I understand that the records released may contain alcohol and drug treatment information, medical information or psychiatric and psychological information.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

_____ _____
Patient/Client Name (Print) Date

_____ _____
Signature (Guardian Signature if Patient is under 18) Date

Mind and Motion Company Policies and Acknowledgements

PATIENT CONFIDENTIALITY RIGHTS

We at Mind and Motion, LLC care about protecting your privacy. Evaluation findings and/or information attained through the therapy/consult session is kept strictly confidential and may not be divulged to any other parties with the exception of the following:

The law (Health Insurance Portability & Accountability Act of 1996; HIPAA) requires the following limits of confidentiality in the therapist-patient relationship under the following circumstances (under these provisions, information may be provided to third parties). Please review the attached Georgia Notice for more specific information on your rights as they pertain to HIPAA.

I understand that, under the HIPAA I have certain rights to privacy regarding my healthcare information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly for the purpose of:

a) *Suspicion of child abuse or neglect of a minor or elderly person requires mandated reporting to the appropriate protective agencies. Suspicion of any physical or sexual abuse as a victim or perpetrator requires mandated reporting to the appropriate protective agencies.*

b) *Threats of suicide (risk to self)*

c) *Threats of Homicidal intentions (risks to others)*

d) *Court order (privilege held by patient)*

e) *Consented release of information*

I have discussed the above limitations with my evaluator/therapist and understand the limits of confidentiality; I have also reviewed the attached Georgia Notice and understand my rights and limitations as they pertain to HIPAA;

Patient or Parent/Guardian Initials:_____

CONSENT FOR AUDIO/VISUAL SURVEILLANCE

Mind and Motion, LLC may monitor testing or therapy behaviors by supervisory staff by the use of cameras and audio sensory in their rooms. These devices do not record or store any surveillance on any medium. The purpose of this monitoring is for our senior staff to unobtrusively monitor behaviors to assess the quality of our test data and provision of certain therapeutic services. This notice is to provide you of our intent and obtain you permission to use this method of quality assurance in our practice.

Signing this consent form demonstrates your recognition and acceptance of this technique in providing services to you or your family member.

Patient or Parent/Guardian Initials:_____

RESEARCH ACTIVITIES

Mind & Motion, LLC actively participates in research programs to facilitate the development of better diagnostic and treatment modalities for the clients we serve. In this context, we often use data collected from our ongoing assessment and treatment programs as a way to further understand brain behavior relationships, to establish better assessment tools, and assess methods to validate treatment efficacy. Identifiers are removed from all data used for research presentations as well as any publications that result from these research activities. In this way, we protect the confidentiality of all the clients we serve. By signing this agreement, you are hereby acknowledging that you recognize it is our standard practice to use our clinical data for research activities and have no objection to the use of any clinical data gathered on you or your family member for these purposes with an understanding that such data is protected by removal of identifiers.

Patient or Parent/Guardian Initials:_____

PATIENT DROP-OFF & PICK-UP POLICY

Due to the nature of the many liabilities associated with parking lot traffic, Mind and Motion expects all patients under the age of 15 to be accompanied to and from the office waiting room during appointment drop-off and pick-up times. Our therapists will not retrieve or accompany minors to their parent or guardian's vehicles before or after appointments.

Patient or Parent/Guardian Initials:_____

SOCIAL MEDIA POLICY

Mind and Motion, LLC acknowledges many social media platforms have made it convenient for people to get connected with business and professionals. Our therapists must have a specific type of relationship with their clients. For this purpose, our policy does not allow patients to: connect with, friend, message, follow, or post on our therapist's personal social media accounts. If an individual wishes to participate with Mind and Motion on social media please do so through the Mind and Motion Company accounts.

Patient or Parent/Guardian Initials:_____

EMERGENCY CONTACT POLICY

An emergency related to you or your family member's condition could arise. If your therapist is urgently needed, please contact them via the method they provided you during your initial appointment. Contacting your therapist through any other means may delay a response.

Patient or Parent/Guardian Initials:_____

CLIENT / THERAPIST EMAIL COMMUNICATION POLICY

From time-to-time our patients may communicate with office personnel and clinicians via email. It is a policy of Mind and Motion not to distribute emails except to those for whom the email message is meant. However, we must still notify you that email notification is not a HIPAA compliant method of communication. Messages will remain on the server from which the emails were sent and received. Communicating via email will be done at your own risk. If you do not wish to communicate in this method do not provide us with an email address on any of our patient intake paperwork or initiate contact with us via email. If email communication has already been established, express in writing to cease email communication with you immediately.

Patient or Parent/Guardian Initials:_____

ACKNOWLEDGEMENT OF RISK FOR THERAPEUTIC EQUIPMENT

I acknowledge there is some risk inherent in the use of the therapeutic equipment at this location/clinic. I agree to indemnify and hold Mind and Motion, LLC from all losses and claims for any injuries or other damage occurring to myself or my child or our belongings from the use of therapeutic equipment. This also applies to any therapeutic activities that my child or I might participate in with therapists outside the building.

Patient or Parent/Guardian Initials:_____

DISCLOSURE OF THERAPEUTIC IMPROVEMENT

Our clinicians strive to make positive therapeutic progress with you or your family member. There are many aspects to therapy, which can contribute to or take away from progress. Aspects can include attendance, diet, level of motivation, implementation of skills or therapy plans at home or school, etc. Even with all of these aspects being held in therapeutic compliance, there is a chance that therapeutic intervention might not work for you or your family. If our clinicians find this to be the case for you or your family member, we will adjust your treatment plan or refer to a place we feel can yield more positive results.

Patient or Parent/Guardian Initials:_____

PATIENT AND CLIENT SATISFACTION ACKNOWLEDGEMENT

In order to help improve both patient/client and the clinicians experience at Mind and Motion, LLC we welcome suggestions to help us improve our customer service. Suggestions can be made directly to our administrative or clinical directors via email. Contact information can be found on staff business cards in our waiting room.

Patient or Parent/Guardian Initials:_____

I have carefully read, clearly understood, and accepted the terms and conditions of Mind and Motion, LLC Company Policies and Acknowledgements stated herein. I acknowledge that this agreement shall be effective and binding upon me, my heirs, assigns, personal representative, and estate and for all members of my family, including minor children.

Patient's Name (please print): _____

_____ _____

Signature (Guardian Signature if Patient is under 18) Date

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 [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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 purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes 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 a 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 an inquiry 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 at 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 Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *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. On 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. On 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, even if you have agreed to receive the notice electronically.

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 provide you a copy at your next appointment, post the revisions, and have the revisions available at the front desk if you are not an active patient.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact, the office manager at 678-749-7600.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on 4-14-2003.

I will limit the uses or disclosures that I will make as follows:

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 posting the revised notice in the office, giving you a copy at the next appointment, or having available copies for you to request if you are not an active patient.