Kevin J. Weis, Psy.D.
Licensed Psychologist
Clinical Child Psychologist

Aimee N. Staley, Psy.D.
Licensed Psychologist
Clinical Neuropsychologist

Lifespan Psychology
5652 Veterans Parkway
Columbus, GA 31904
P: 706-507-5444 F: 706-507-5484

Patient Information
CHILD
(Please print clearly)

Date _____ Doctor (Pick one)___Dr. Weis_____Dr. Staley_____
(Circle one)

Child's Full Legal Name _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ SS#: **Please have prepared for first appointment** Sex _____

Date of Birth _____ School _____ Grade _____

Mother/Guardian _____

Date of Birth _____ SS# **Please have prepared for first appointment**

Work # _____ Cell # _____Email: _____

Which method is best/most reliable/ or preferred: Work / Cell / Email?

Father/Guardian _____

Date of Birth _____ **Please have prepared for first appointment**

Work # _____ Cell # _____Email: _____

Which method is best/most reliable/ or preferred: Work / Cell / Email?

Name of Primary Care Physician _____ PCP Phone# _____

How were you referred to us?_____

Person we should contact in case of an emergency: _____
Name Relationship Phone Number

I HEREBY GIVE MY PERMISSION FOR MY CHILD TO RECEIVE SERVICES:

Signature of Mother/Father/ Guardian _____ Date _____

INSURANCE INFORMATION

Name of Primary Insurance	Name of Secondary Insurance
Policyholder's Full Name	Policyholder's Full Name
Policyholder's date of birth	Policyholder's date of birth
Policyholder's Social Security Number	Policyholder's Social Security Number
Policyholder's Employer	Policyholder's Employer
Policy/ID Number	Policy/ID Number
Group Number	Group Number
Insurance Telephone Number	Insurance Telephone Number

Patient's or authorized signature. I authorize the release of any medical information necessary to process my claim.

SIGNED_____ DATE_____

I authorize payment of medical benefits to the above named medical provider.

SIGNED_____ DATE_____

Do we have your permission to send a letter of acknowledgement to the person who referred you to our office?

Yes _____ No _____

SIGNED_____ DATE_____

Briefly describe reasons for seeking treatment, list current symptoms and difficulties:

_____

_____

Past Medications (Names, Dosage, Frequency) | **Current Medications** - *WHO PRESCRIBED*?

PLEASE ANSWER YES or NO to following Questions

Medical History

- Abuse (Physical, Sexual, Emotional):
- Excessive concerns / anxiety / fear:
- Obsessive / compulsive tendencies:
- Tactile Defensiveness:
- Eye Contact:
- Preoccupation w/ parts or objects:
- Spontaneous sharing enjoyment:
- Social / emotional reciprocity:
- Tics / Self-stimming:
- Difficulty w/ transitions:
- Sleep disturbances: getting to or staying asleep or going to bed -
- Average number of Sleep Hours:
- Nightmares:
- Needs / wears glasses: Farsighted or Nearsighted
- Chronic Ear Infections / hearing difficulties:
- Surgeries:
- Hospitalizations:
- Head injuries / Concussions:
- Dizziness:
- Headaches
- Stomach aches:
- High Fevers over 104 degrees:
- Seizures:
- Allergies:
- Allergic Reactions:
- Asthma:
- Exposure to lead / toxins:

Family Medical History (If yes, Who?)

- Anxiety - Depression - Legal Involvement (Arrests, incarcerations, probations, parole):
- Obsessive / Compulsive: - Bipolar: - ADHD / Behavior Difficulties:
- Autism or Aspergers: - Schizophrenia

LATE CANCELLATION/MISSED APPOINTMENT POLICY

We reserve several hours for neuropsychological testing for each person scheduling an appointment. If someone cancels late or misses an appointment, we are unable to offer that time to someone who may be waiting. Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, that we have ample notice.

We do require a 24 hour notice on a cancellation in order to release you from your responsibility for that time scheduled. **You will be billed $75.00 for late cancellations and missed appointments. Please note that insurance does not reimburse for cancelled sessions.**

I agree to the above terms of the late cancellation/missed appointment policy and will make prompt payment on any charge I incur for late cancellation or missed appointments.

_____ _____

Signature Date

Guarantor Financial Responsibility

Every patient is responsible for knowing the specific requirements of their insurance companies. With so many different insurance plans, it is unrealistic for our staff to know the specific requirements for all policies. Please let us know if you are required to have or use one of the following:

1. **Authorization/Pre-certification** requirement for mental health treatment.

2. **A written referral from your Primary Care Physician (PCP)**. It is the patient's responsibility to obtain referral prior to their appointment.

If you are unsure about your insurance requirements, please contact your employer's personnel/human resources representative at your work or your insurance agent prior to your appointment.

I have read the above and understand that it is my responsibility to make sure all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with Lifespan Psychology that result from non-covered services or my failure to meet insurance requirements.

_____ _____

Signature **Date**

Lifespan Psychology
Consent to Release Information

I,_____, in care of _____

(Parent or Guardian) (Name of Child)

hereby give informed consent for Lifespan Psychology: Kevin Weis, Psy.D. / Aimee Staley, Psy.D. to (please circle)

1. Talk with and/or
2. Release written documentation
3. Receive written documentation

regarding my treatment to _____.

Name of Physician / Person

Phone Number: _____

Fax Number: _____

I understand that my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse and under the general laws of my state and cannot be redisclosed without written consent, except as specifically stated by law.

I understand that, under Federal law, the above-named provider may release information from my record without my consent when:

1. there is indication of child abuse or abuse of disabled adults;
2. given best clinical judgment, there is indication of dangerousness to self or others (suicidal or homicidal);
3. required to present records to comply with a court order.

I understand Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

This authorization remains in effect as long as I remain an active patient at Lifespan Psychology. I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation. In the event action already has been taken prior to said receipt of revocation, such prior actions are covered by the pre existing release.

_____

Signature of Member Date

_____

Signature of Witness Date

Notice of 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 *written authorization*. 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.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

• II. Other 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. 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 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 without 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 a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.
- *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization 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 must be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

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 and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access 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 with the changes either by giving you the revisions in person or by mail.

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 me at 4 Bradley Park Ct, Ste. 1B, Columbus, GA 31904. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy 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 then provide you with the revisions either by giving them to you in person or by mail.

_____ _____

Signature Date