WELCOME TO OUR OFFICE

The Stevens Clinic
405 South Thornton Ave.
P.O. Box 1927
Dalton, GA 30722
(706)226-1146

PERSONAL DATA

Patient Name: _____ SSN: _____

Age:_____ Birthdate: _____ 2nd ID# (Driver's License)_____Race:_____

Language:_____ Marital Status:_____ Primary Care Physician:_____

( ) Home Phone:_____( )Cell Phone:_____( )Work Phone:_____Check preferred contact #

Mailing Address:_____City _____ State _____ Zip _____

Email:_____

Student (Full/Part Time or None):_____

Employed (Full/Part, Retired, Not Employed)_____

Emergency Contact: Name _____ Phone _____

Cell Phone:_____Relationship to Patient:_____

EMPLOYMENT - INSURANCE DATA

Insured: _____Relationship to Patient:_____
Birthdate:_____ SSN:_____Employer:_____
City:_____State:_____ Zip:_____Phone:_____

Primary Insurance Company: _____
Policy ID #:_____Group #:_____

Secondary Insurance Company: _____
2nd Insured's Name: _____ Relationship to Patient:_____
Birthdate:_____ SSN: _____Employer:_____
City:_____State:_____Zip:_____Phone:_____
Policy ID #: _____ Group #:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE.
I hereby authorize this office to release any information necessary to expedite insurance claim processing. This is a direct assignment of my rights and benefits under this policy.

YOUR APPOINTMENT TIME IS RESERVED ESPECIALLY FOR YOU. If you cannot keep your appointment with The Stevens Clinic, please notify this office at least 24 hours in advance. Failure to notify the office (we have a 24-hour answering system) will result in a charge to you. The initial appointment no show/cancellation fee is $75.00, the follow-up appointment no show/cancellation fee is $50.00. This fee is to be paid in full before the missed or canceled appointment can be rescheduled.

Patient/Guardian Signature _____ Date _____

THE STEVENS CLINIC

P.O. Box 1927 Dalton, GA 30722
Tel: (706) 226-1146 Fax: (706) 226-1483

The Stevens Clinic Office Hours
Monday,Tuesday, Wednesday and Thursday 8:00 am to 6:00 pm, Friday Closed

INFORMED CONSENT FOR PROFESSIONAL SERVICES

The goal of The Stevens Clinic is to provide first quality professional treatment for psychiatric and psychological problems in a caring, Christian environment. The following agreement states policies with regard to appointments, fee structure, payment arrangements, general information, client responsibilities, and confidentiality.

INTAKE INTERVIEW. The intake interview is an opportunity for the doctor and client to begin identifying and evaluating the situation the client presents. The main goal of this initial interview is to match the identified needs of the client with the most helpful resources available. Hopefully, we can provide these resources at The Stevens Clinic. Occasionally, this will mean a referral to another professional or outside agency. The goals of treatment are to be set by both the client and doctor so that they are clear, realistic, and focused. It is not the doctor's role to direct or persuade the client to make choices against his or her better judgement. The client's role will be to evaluate alternatives and accept responsibility for any choices made.

LIMITATION OF SERVICES. I understand that The Stevens Clinic's services are limited to psychological and psychiatric evaluation, assessment, consultation, and intervention. I understand that evaluation and assessment services may involve the use of psychological tests. I understand that the professionals at The Stevens Clinic are committed to Biblical Christianity and that such will be reflected in their caring treatment of persons and in their optimistic treatment of problems. Depending on the comfort of clients, therapy sessions may incorporate prayer. I also understand that I can expect the professionals at The Stevens Clinic to be at all times respectful of clients with different worldviews and religious faiths. I understand that The Stevens Clinic is not promising a cure or offering any guarantee of results or improvement of any condition.

ASSUMPTION OF RISKS. I understand that the potential benefits of undergoing psychological services include obtaining a professional opinion, an increased understanding of my child or myself, and an improvement in my particular condition or that of my child. I understand that potential risks may include limited precision assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my own situation or my child's situation.

SCHEDULING APPOINTMENTS, CANCELLATIONS, MISSED APPOINTMENTS & LATE ARRIVALS. Appointments will attempt to be scheduled at a time convenient to both the client and the doctor. If a client is unable to keep an appointment, the client should notify The Stevens Clinic at least 24 hours in advance. Clients failing to notify the office 24 hours in advance will be charged a missed appointment fee. Insurance policies will not pay for missed appointment fees. Clients arriving late to appointments are responsible for the regular session fee although the full time reserved will not be available. In case of inclement weather (e.g., snow and ice) please call the office to determine if it will be open. Telephone calls of a routine nature should be made during regular office hours and will be attended to by our office manager, Stephanie. If Stephanie is unable to answer a question, the doctor will receive the message and typically will return the call between appointments or at the end of the day. The Stevens Clinic is connected to an answering system that will take calls if the lines are busy. After business hours, calls will be answered by a voice mail system, with options for leaving the doctors messages or paging them in the case of an emergency.

CONFIDENTIALITY. I understand that my child's or my disclosures and communications are considered privileged and confidential. My records are protected under federal and state regulations governing confidentiality and cannot be disclosed or released without my written consent unless otherwise provided for the in the regulations. In the process of ongoing therapy, my case may be discussed among the clinical staff for purposes of supervision or case consultation. I also understand that confidential and privileged information may be released without my consent or authorization under the following circumstances:

1. If you threaten to harm either yourself or someone else and we believe your threats to be serious, we are obligated under law to take whatever actions seem necessary to protect you or others from harm. This may include divulging confidential information to others, including law enforcement personnel.
2. If we have reason to believe that a child, an elderly adult or handicapped individual is being abused, neglected or exploited, we are mandated by Georgia law to report this to the appropriate agency.
3. If you are a member of a managed care insurance plan or of an employee assistance program and elect to use your benefits, it may be necessary to make available to your insurance company certain diagnoses, treatment plans and other required information to receive payment.
4. If you are involved in litigation of any kind and your mental health becomes an issue before the court, your treatment records may be mandated for disclosure to the court, but only by a duly authorized court order.

CLINIC FEES & PAYMENT POLICIES

METHOD OF PAYMENT. Cash, check, credit card and most insurance are accepted. Checks should be made payable to "The Stevens Clinic."

CREDIT CARD (MasterCard, American Express, and Visa). Clients paying by credit card must present the card (not just the number) at the time of the charge. An authorization number will be secured by telephone at the time of the charge. If authorization is not received, the client will be responsible to make payment by some other means at that time.

INSURANCE. If clients have insurance that will cover services and the doctor is an approved provider, The Stevens Clinic will gladly file a claim for payment for the client. Clients must sign the insurance intake form assigning the benefit payment to The Stevens Clinic. The client is responsible, at the time services are rendered, for the difference between insurance payments and the fee determined for services rendered. Most insurance companies have a deductible amount that must be met before the coverage begins. The client is responsible for paying the deductible amount, if any, first. Thereafter, claims are filed monthly, eliminating paper work for the client and assuring that claims are filed promptly. If for any reason there is an over-payment of an account by the client and the insurance company combined, The Stevens Clinic will promptly credit the account or reimburse the client, whichever he or she chooses.

FEES. The fee for services of a licensed psychiatrist is $250.00 for the intake interview and $125.00 for a routine medication evaluation. The fee for services of a licensed psychologist is $250.00 for the intake interview and $175.00 per 50-minute therapy session thereafter. Clients are expected to make arrangements for full payment of fees immediately after services are rendered. At times it may be necessary or appropriate for you to telephone your doctor. A pro-rated fee may be charged for lengthy calls. If psychological testing is administered, the charges will vary. These charges will be explained at the time the testing is scheduled. If you cannot keep your appointment, please notify The Stevens Clinic 24 hours in advance. Failure to notify the office (we have a 24-hour answering system) will result in a $50 charge to you. There is a $25.00 fee for the retrieval and photocopying of any medical records. Checks returned for insufficient funds will be charged a $30.00 processing fee. The financial responsibility agreement form must be signed before services can be rendered.

FINANCIAL RESPONSIBILITY OF SECOND PARTY. If someone other than the client is responsible for the payment of services rendered, this party will need to sign the financial responsibility agreement form with The Stevens Clinic before services can be rendered.

NONPAYMENT. If a client does not abide by the financial responsibility agreement of The Stevens Clinic regarding the payment of fees, The Stevens Clinic may choose to employ a collection agent. The client will then be responsible for the collection agent's fee in addition to his or her own fees. Failure to pay a bill constitutes a waiver of the right to confidentiality concerning the client's name, address, telephone number, social security number, dates of service, dates of payment, amount owed, and the name and address of the employer. No other information about the nature of the services or the content of the sessions will be disclosed without the client's written permission. I hereby hold The Stevens Clinic harmless for any consequences which may occur if my account is turned over to a collection agent.

INFORMED CONSENT AGREEMENT

I hereby voluntarily apply for and consent to professional services provided by The Stevens Clinic. This consent applies to the child, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I further certify that I have understood to my satisfaction the accompanying information regarding limitation of services, assumption of risks, and confidentiality. By signing, I understand and agree with all the terms and conditions of this information.

_____ _____

Patient Date

_____

Parent or Guardian

FINANCIAL RESPONSIBILITY AGREEMENT

I understand I will be charged a fee for all professional services rendered. I agree to arrange for payment in full of all fees immediately after services are rendered. The Stevens Clinic reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. I also authorize and hold The Stevens Clinic harmless for the release of any and all information requested by my managed care company, insurance company, Workers Comp company, or Medicare for the purpose of processing my insurance claim and obtaining payment for services. I have read, understood, agree with and will comply with the above mentioned fee and payment policies.

_____ _____

Responsible Party Date

_____ _____

Address (if different from patient's) Home Phone

_____ _____

Employer (if different from patient's) Work Phone

PRIVACY POLICY AGREEMENT

I hereby acknowledge that I have been presented with a copy of The Stevens Clinic's Privacy Policy.

_____

Patient Date

_____

Parent or Guardian