Powers Ferry Psychological Associates, L.L.C.

PATIENT INFORMATION

Patient's Name _____ **Sex** ___ **Date of Birth** ____/___/_____ **Age**____

Employer/School _____ **SSN** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Phone ~ Home (_____)-_____ **Work** (____)-_____ **Cell** (___)-_____

E-mail _____

If patient is a minor: **Names of Parent(s)/Guardian(s)**_____

RESPONSIBLE PARTY INFORMATION ☐ Check if same as patient (skip this section)

Guardian Name _____ **Sex** ___ **Date of Birth** ____/___/_____

Relation to Patient _____ **Party's SSN**_____ **Employer** _____

☐ **Same address as the Patient** ☐ **Different address than the Patient** ***(Please complete address below)***

Street Address_____

City_____ **State** _____ **Zip** _____

☐ **Same home phone as the Patient** ☐ **Different home phone: Home** (___)-_____

Other Phones: Work (____)-_____ **Cell** (___)-_____**Email** _____

INSURANCE INFORMATION ~ Please Provide Insurance Card ~

Policyholder's Name_____**Policyholder's SSN** _____

Date of Birth ____/___/_____ **Primary Insurance Co. Name** _____

Insurance Company's Customer Service Phone # _____**Insurance ID #** _____

Policyholder's Employer:_____**Group #**_____

Co-pay $_____ **Deductible?** ☐ **Yes** ☐ **No** **Amount $**_____

Authorization Required? ☐ **Yes** ☐ **No** **Authorization #** _____

Number of Sessions Authorized _____ **Maximum Number of Sessions Allowed Per Year**_____

Is the patient covered under a secondary insurance policy? _____ ***If yes*, please see the applicable paragraph under the Insurance Reimbursement section in the following agreement.**

How did you hear about us?

Friend/Relative:_____ Health Professional:_____

Website:_____ Insurance Company:_____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PROFESSIONAL SERVICES AGREEMENT, VERSION 4-14-03, AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

Signature of Patient or Parent(s)/Guardian(s) **Date**

Name of Patient or Parent(s)/Guardian(s) ***(Please print)*** **Relationship(s) to Patient**

OTHER ADULT PARTY/PARTIES INVOLVED IN TREATMENT ☐ **NOT APPLICABLE**

Signature of Secondary Party/Parties **Date**

Name of Secondary Party/Parties ***(Please print)*** **Relationship(s) to Patient**

TREATING PSYCHOLOGIST

Signature of Treating Psychologist **Date**

Name of Treating Psychologist

Powers Ferry Psychological Associates, L.L.C.
1827 Powers Ferry Rd., Bldg. 22, Suite 200, Marietta, GA 30067-9410
770.953.4744 Fax: 770.953.4640

NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

I, the undersigned, acknowledge that I have received, read and understand the "*Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information*" form from Powers Ferry Psychological Associates (Version 04/14/2003).

This policy became effective April 14, 2003 as required by law under HIPAA (Health Insurance Portability and Accountability Act).

_____ _____
Signature of Patient or Parent(s)/Guardian(s) **Date**

_____
Name of Patient or Parent(s)/Guardian(s) ***(Please print)***

If applicable, secondary party/ parties , 18 years of age or older, participating in treatment:

_____ _____
Signature of Secondary Party/Parties **Date**

_____ _____
Name(s) of Secondary Party/Parties ***(Please print)*** **Relationship to Patient**

_____ _____
Signature of Treating Psychologist **Date**

_____
Name of Treating Psychologist