INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your psychologist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your evaluation. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of the evaluation. If your minor child/adolescent is the client, you are completing this form on their behalf.

Background Information

The following information regarding my educational background and experience as a psychologist is an ethical requirement of my profession. If you have any questions, please feel free to ask. I obtained my undergraduate degree in Psychology from the University of Georgia. I also obtained my Master's of Education in Community Counseling and Ph.D. in Counseling Psychology from U.G.A. I am a licensed psychologist in the state of Georgia and have been in private practice since 2004.

Evaluation Services

A psychological evaluation involves an assessment of intellectual functioning, processing skills, academic functioning, and social-emotional functioning. Background history and teacher input, as well as previous records, provide additional information to assist in diagnosis. Evaluations involve 4 to 6.5 hours of testing, 1.5 hours for a conference, and 1.5 hours billable time to complete the written report. A copy of the report will be mailed within a few weeks following the conference. The report will be extensive and will include all scores from the testing. I am not permitted to provide copies of the tests due to laws protecting this information. **Once the testing is scheduled, you will be expected to pay for the first day of testing unless you provide 48 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for a cancelled session. On the rare occasion when a child is non-compliant with the testing process and the testing cannot be completed, you will be expected to pay for the time spent working with your child and any additional time required to write a summary.**

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Please initial that you have read this page _____

In addition, you should be aware that I practice with other mental health professionals and that I employ an administrative staff. In most cases, I need to share protected information with these individuals for both administrative and clinical purposes such as scheduling, billing, and quality assurance. I also have contracts with typing associates who have a formal business associate contract with me that requires them to maintain confidentiality. All mental health professionals are bound by the same rules of confidentiality and all staff members and business associates have been given training about protecting privacy and will not release information without my permission.

Structure and Cost of Sessions

I agree to provide psychological testing for the fee of $400.00 per 60 minute testing session. I also charge this amount for other professional services you need, though I will break down the cost if I work for periods of less than one hour. Other services include report writing, telephone calls that exceed 10 minutes in duration, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any service you request of me. **You will be expected to pay for the full psychological evaluation on the first day of the assessment by cash or check made to Sandy Springs Psychological Center.** I will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. It is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to assist you with any questions you may have in this area. **I do not file insurance forms directly and I cannot guarantee reimbursement through any insurance company.** Please be aware that I am an out-of-network provider for all insurance companies.

If you become involved in legal proceedings that require my professional participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation and attendance at any legal proceeding.

Overdue accounts of more than 60 days are subject to late fees and may be turned over to collections to obtain payment. When accounts are turned over to collections your name, date of service, and account balance will be shared. No information related to your treatment will be revealed.

Minors and Parents

Patients under the age of 18 who are not emancipated and their parents should be aware that the law allows parents to receive the results of the psychological evaluation. Families may decide who will attend the conference to review the test results following the evaluation.

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.455.3200

Please initial that you have read this page _____

- Call 911.
- Go to your nearest emergency room.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. **However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.**

Facebook, LinkedIn, Instagram, Pinterest, Etc: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Our Agreement to Enter into a Relationship for Psychological Evaluation

I am sincerely looking forward to working with you in the evaluation process. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your psychologist, and you are authorizing me to begin evaluation with you.

Please initial that you have read this page _____

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Paul J. Cohen, Ph.D. **Date**
GA Licensed Psychologist No. 2928

Please initial that you have read this page _____