WELCOME

Douglasville Psychotherapy Center at Oakhill, P.C.

We are pleased you have chosen Douglasville Psychotherapy Center at Oakhill as your therapist. We are committed to providing you the best care possible. To acquaint you with our policies and procedures the following information is provided for your review.

Fees/Appointments / Cancellations: If you need to reschedule or cancel an appointment, **a 48 hour notice is required to avoid a charge of 100% of your providers scheduled fee time.**

Dr. Annie Prescott, PhD fees are the following:

$175.00 Initial Session; $165.00 Individual Session; $175.00 Family Session

(Full price will be charged for scheduled missed appointment)

Donna Watkins, LPC fees are the following:

$80.00 Initial Session; $70.00 Individual Session; $80.00 Family Session

($60.00 for any missed appointment)

This charge also applies if you simply fail to keep your scheduled appointment. Emergencies are the exception and will be discussed on case by case basis. In the evening or weekends you may leave a message on the voicemail system which will record the date and time of your call. Our providers will do their best to be punctual for your scheduled appointment time; unless they are dealing with an emergency call or crisis situation. If you are late for any reason you will be seen for the remainder of your scheduled time. **If you have Medicaid affiliated insurance please be aware that missed appointments could impact treatment prognosis and insurance coverage.**

Confidentiality: As a professional office we are committed to your privacy and maintaining the confidential nature of your treatment. We will require a complete "Release of Information" form if you desire information to be communicated to anyone not involved with your counseling process. We are required by law to report issues pertaining to real or suspected child abuse or threats to do harm to self or others. Additionally, if you are filing for insurance reimbursement or you are a subscriber to a managed care or EAP contract that is held by DPCO provider, your clinical information may require responding to potential request for information from the third party payer.

Emergencies: Our regular business hours are Monday through Thursday 8:00am till 5:00pm and on Fridays till 12:00pm. Douglasville Psychotherapy Center at Oakhill, P.C. is not an emergency admitting facility. In case of an emergency, your options include: Call 911, go to your nearest emergency admitting facility, call the 24hr Cobb/Douglas crisis line (770-422-0202). If you need to contact your provider or the office staff for non-emergencies, please call the office and leave a voicemail message and your call will be returned the next business day. Please also note: In the event of inclement weather please contact our office to be assured of any unforeseen closings. Douglasville Psychotherapy Center at Oakhill will do our best to contact you as well. We care about you and our staff and do not choose to take unnecessary risks, however please **Do Not Assume Any Cancellation.**

DOUGLASVILLE PSYCHOTHERAPY CENTER AT OAKHILL (DPCO)

1111 Bakers Bridge Road
Douglasville, Georgia 30134
770-947-2311

Welcome,

These are a few friendly reminders about OAKHILL:

*Since parking is limited, please park in the marked parking area.

*Since the waiting area is small, please limit persons who accompany the patient being seen.

*This is a totally, non-smoking facility.

*Please personally dispose of any cigarette butts and refrain from throwing them in the driveway or grassy areas.

*Please do not bring food or drinks inside the building.

*Please properly dispose of trash before entering the building.

*Please do not leave your children unattended.

*Please assist little ones under the age of 6 going up and down the stairs.

*Please accompany children under the age of 10 to the restroom, located downstairs.

*Please do not wander the property without staff escort.

*Please do not feed or touch the animals without staff guidance.

*Please inform DPCO staff of cancellations within 48 hours to avoid a No Show Charge.

We appreciate your understanding and respect for this sacred space.

Sincerely,
Dr. Annie Prescott

Rev. date 11/2017

DR. MARCIA ANNE PRESCOTT, PHD, CCS, CACII, CCJTS
INFORMED WRITTEN CONSENT FOR TREATMENT POLICY STATEMENT FORM

Thank you for selecting me as your psychologist. The intent of this statement is to inform you about the basic therapeutic relationship between psychologist and patient, to inform you of basic policies, and to help you understand our professional relationship.

Psychotherapy Philosophy, Expectations of Patients

I believe in the capacity of people for self-efficacy. This means that you are able to personally create an improved quality of life and you are in charge of your goals and personal growth. We will work collaboratively to achieve these personal goals. My approach to therapy involves mind, body, and spirit through the use of evidence-based practices. We will together examine issues related to your self-relationship and relationships with others.

Your decision to choose to enter psychotherapy is a voluntary one and you may terminate at any time. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because of ethical standards. I will provide you with the contact information of the referral. Please note that it is impossible to guarantee any specific results regarding your psychotherapy goals; however, we will work together to achieve the best possible results. At the end of the first session, we will decide if we want to enter into a psychotherapy relationship. If we both agree, you will sign, date, and keep a copy of this informed consent.

Scope of Practice

I operate in an outpatient private practice consisting of traditional talk therapy, equine therapy, and animal assisted/Integrative experiential therapies. I work with children, adolescents, and adults. I cannot and do not assume responsibility for patients daily functioning as an institution can. I am not an emergency facility for crisis management. I make every effort to return phone calls during office hours as quickly as possible but there may be unavoidable delays. I can be reached at 770-947-2311 from 8am-5pm, Monday through Thursday. IN THE EVENT OF AN EMERGENCY, you should call 911 or go to the emergency room.

Ethical Guidelines and Standards

I assure you that my services will be provided in a professional manner consistent with accepted ethical standards for licensed psychologists. If at any time you are dissatisfied with my services, please let me know so that we can discuss and hopefully resolve your concerns.

Confidentiality

Please understand that I will keep confidential what you disclose, with the following exceptions:

1. You direct/allow me to tell someone by signing a release of information form.
2. I determine you are a danger to yourself or others.
3. I am ordered by a court to disclose information
4. You abuse a child or an elderly person.

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction and you agree to adhere to policies specified in this document.

_______________________________ Printed Name

_______________________________ Date

_______________________________ Patient Signature

_______________________________ Guardian Signature for patients younger than 18 years of age

Douglasville Psychotherapy Center at Oakhill, P.C
Patient Information and Financial Agreement

(Please Print Legibly)

PATIENT INFORMATION

Please use full legal name (no nicknames please)

Last ______________________ First ______________________ MI _________

DOB _____________ Age _____ M/F ______ SSN _________________________

Physical Address ____

Mailing Address ____

City ____________________________ State _______ Zip _______________

County ________

Cell/Home Phone ________________ E-Mail __________________

PARENT/GUARDIAN (Person responsible for care and financial situations)

Last _________________ First ______________________ MI _______

DOB ____________ SSN ________________ Occupation _________________

Mailing Address ____

Primary Phone ____________________ Secondary _________________________

Employer _________________________ Work Phone _______________________

E-mail ____

Other parent/guardian _______________________ Phone _________________

Are parents separated or divorced? Yes _____ No ______

If you are not a parent, are you the legal guardian? Yes ______ No ______

Best number to confirm your appointment? _________________________________

YOU WILL NEED TO SHOW PROOF OF CUSTODY OR GUARDIANSHIP

ADDITIONAL INFORMATION

Referring Physician or Psychiatrist (Please provide doctors full name)

Phone# Diagnosis ____

If patient has seen other mental health professionals, please include psychians name and diagnosis____

INSURANCE INFORMATION (Please fill out completely)

Primary Insurance name _______________________________

Insurance ID#__________________________

Policy Holder's Name DOB ______________________________

SSN _________________________ Relation to Patient _________________________

Group Number _____________________ Employer ___________________________

Secondary Insurance Name ____________________ Insurance ID# ________________

Policy Holder's Name ________________________ DOB ________________________

SSN _________________________ Relation to Patient _________________________

Group Number _______________________ Employer____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT (Initial=Int.)

Init.______ I request that all insurance benefits be paid directly to Douglasville Psychotherapy Center at Oakhill, P.C.

Init.______You are entitled to a clear understanding of your financial obligations before services are rendered. We participate with numerous managed care plans and to the best of our ability, certify your benefits prior to being seen. It is not possible for us to know all of the individual requirements of each plan. Your employer negotiates the benefits of your plan and we have no control over how claims may or may not be processed. Each plan is different in regards to what is covered, how often and where services may be rendered. Whether you have insurance or are self-pay, we maintain that you are ultimately responsible for all charges incurred.

Init. ______ We do not file indemnity plans, non-contracted or secondary insurance carriers. We try to assist you in getting services covered; but are not responsible if they are not covered under your contract and you will be billed. It is your responsibility to ensure that a referral and/or authorization has been obtained if necessary. If we do not have a referral on file, we are happy to see you as a self-pay patient. For a self-pay patient, full payment is required at the time of service

Init. ______ If insurance cannot be verified by date of service, we expect payment in full. We accept cash, check and credit card. If you do not have insurance, we expect payment in full, unless prior arrangements have been made with the business office.
***Co-pays are due at time of service; if it is not paid at the time of service, we will bill you with an additional administrative fee of 15% per visit.

***There is a per page fee for any written communication, to be paid at time of completion. Once requested, this fee will apply whether you choose to utilize it or not.

***Please make all checks payable to Douglasville Psychotherapy Center at Oakhill.

*** We charge a $35.00 returned check fee.

***Cancellation fees: $170.00 -individual therapy; $180.00-family therapy, or amount equivalent to reserved time for cancellation with less than 48 hours notice.

***No-show fees are billed to you directly and are your responsibility. Insurance will not pay.

***Medical records can be obtained with signed release and applicable administrative fees at time of release.

***This office practices Credit Bureau reporting for all delinquent balances.

Init.______ I acknowledge understanding for above.

I have read, understand and accept the terms of this financial policy. I have been provided a copy of the Privacy Practices Notice.

Date ______________________________
Responsible Party or Patient/Client Signature ______________________________
Printed Name ______________________________
Signature of Staff/Witness ______________________________

DOUGLASVILLE PSYCHOTHERAPY CENTER AT OAKHILL (DPCO), P.C.

1111 BAKERS BRIDGE ROAD
DOUGLASVILLE, GA 30134

(PH): 770-947-2311
(FX):770-947-2347

I, ______________________________________, have read, understand and accept the terms of the

(printed name)

general rules and guidelines at Douglasville Psychotherapy Center at Oakhill, P.C. I have been provided

a copy of the Rules in the Welcome letter handout.

X____ Date:_________________________
Responsible Party or Patient/Client Signature

____
Printed Name

____ Date:_________________________
Signature of Staff/Witness

HIPAA Notice of Privacy Practices Statement

Douglasville Psychotherapy Center at Oakhill, P.C.

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT for example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT for example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

WITH YOUR WRITTEN AUTHORIZATION we may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION.

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/ administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice when you obtain care.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason of the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

To Request that We Contact you by Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

CONTACT INFORMATION:

If you have questions about this Notice or believe your privacy rights have been violated, you may contact:

The Secretary of the Department of Health and Human Services
Contact the Office for Civil Rights
1-866-627-7748, 1-800-537-7697 (TTY)
http://www.hhs.gov/ocr/privacy/hipaa/complaints/
Filing a complaint will not affect the services you receive at Douglasville Psychotherapy Center at Oakhill, P.C.

By law, Douglasville Psychotherapy Center at Oakhill, P.C. is required to follow the terms in this privacy notice. Douglasville Psychotherapy Center has the right to change the way your personal health information is used and given out. If Douglasville Psychotherapy Center makes any changes to the way your personal health information is used and given out while you are a current client, you will get a new notice, directly or by mail, within 60 days of the change.

Oakhill Medical Release

Date of Release________________

Name____________________ DOB (mm/dd/yyyy)____________

Address____

Phone Number (   )____________________

I give Douglasville Psychotherapy Center at Oakhill, P.C. permission to contact the following person in case of a medical emergency:

Name_________________________

Phone Number (   )____________________

Additionally, I give permission for Douglasville Psychotherapy Center at Oakhill, P.C. staff to contact 911 and/or emergency personnel to assist in the case of an emergency.

Please Note: Please take care when entering & exiting the property by driving slowly into the parking area, watching out for children, other cars or loose animals. Also, while taking the stairs up and down into the center, hold the hand rails and step carefully. Please hold on to small children and monitor them, while inside and outside the building to ensure that they do not exit. Parents/guardians will accompany all children under age of 10 to the downstairs restroom.

Signature of Patient or Guardian:____________________ Date:_______

Signature of Staff/Witness:_________________________ Date:_______

Rev. date 11/2017

Douglasville Psychotherapy Center at Oakhill, P.C. (DPCO)

Patient Confidentiality

We request all cell phones and electronic devices be turned off during sessions for further patient confidentiality.

Patient confidentiality is a top priority at Douglasville Psychotherapy Center at Oakhill. Therefore, it is important that you provide us with th following information to ensure that there is no violation of your privacy.

I acknowledge that I have been made aware of the "NOTICE OF PRIVACY PRACTICES" for Protected Health Information on the date se forth below.

Due to HIPAA guidelines, DPCO staff does not use email, social media, fax or text to communicate with patients. Please call 770-947-231 for any necessary correspondence.

In the event that I am unable to be reached, DPCO may leave any appointment or account information in the following manner:

____ You may leave messages on my home voicemail. Home No.______________________

____You may call my work number and leave a message. Work No.______________________

____You may leave messages on my cell voicemail. Cell No.______________________

____You may share appointment and account information with my spouse. Name ______________________

Phone No. ______________________

____You may share appointment information with my children. Name:______________________Phone No.______________________

____You may share my appointment and account information with the following:

Name ______________________Phone Number ______________________Relationship to Patient ______________________

Name ______________________Phone Number ______________________Relationship to Patient ______________________

_____ In the event you are unable to reach me; DPCO may not leave appointment information or account information with anyone but myself.

Proxy Permission Form: The following person(s) may make medical decisions and sign any appropriate documents related to my child's care in my absence/or myself.

Name of Proxy (Please print) Relationship

______________________ ______________________

______________________ ______________________

Signature of Patient or Guardian Date Relationship to Patient

____

Rev. date 11/2017

Douglasville Psychotherapy Center at Oakhill, P.C.

1111 Bakers Bridge Rd
Douglasville, GA 30134
770-947-2311

Release of Information

I, ____, do hereby authorize ________________________________ or any representative at Douglasville Psychotherapy Center at Oakhill to:

_____ **Release** _____ **Receive** _____ **Exchange**

Information concerning ________________________ (client name)______________ (DOB)
if not Patient or Client: Relationship to Client/Patient ______________________________
To ______________________________ With ________________________(Company)
Address _____________________ City ____________________ Zip ____________
Phone ______________________ Ext ______________ Fax ____________________
I understand that such disclosure will be made for the following purposes: (please check all that apply)

_____Treatment Progress _____ Child Custody/Visitation _____ Treatment Planning

_____ Psychosocial History _____ Medical Treatment _____ Treatment Summary

_____ Reimbursement for Treatment _____ Attendance/Participation _____ Other

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Douglasville Psychotherapy Center at Oakhill, P.C.

If no prior notice of revocation is received, this consent will expire automatically one (1) year after the date indicated thereon.

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 HIPPAA Privacy Rule.

I have read, or have had read to me, the above, and understand the contents.

_____ I authorize this information to be faxed to the party indicated above, and understand the limits of confidentiality which doing so creates.

_____ I give my permission for my provider to communicate with the Primary Policy Holder to process my insurance claim and/or billing resolutions.

______________________________(Signature of Client, Parent, or Legal Guardian)

______________ Date

______________________________ (Signature of Staff/Witness)

______________ Date

DOUGLASVILLE PSYCHOTHERAPY CENTER AT OAKHILL, P.C.

1111 Bakers Bridge Road

Douglasville, GA 30134

770-947-2311

DATE ______________________________

I, ____, agree to contract for safety and abstain from self-harm. I agree to discuss any thoughts or intent to harm myself. I will actively participate in my therapy. I will seek help by calling 911 or by going to the nearest ER facility if I need additional emotional support.

PATIENT ______________________________________

PARENT ______________________________________

THERAPIST ______________________________________