

Christina M. Hall, PsyD, P.C.

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**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 treatment. 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 your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

The following information regarding my educational background and experience as a therapist 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 Tulane University in New Orleans, Louisiana. Moving to New Orleans to attend college, I was inundated with the extraordinary mixture of Creole, Cajun, French, Spanish, and African cultures; new places and people that I would have never experienced otherwise. My experiences in New Orleans compelled me to participate in the Semester at Sea program, through which I had the opportunity to sail around the world for 100 days. I came away from this voyage with a deep respect for different ways of life and learned that beauty and spirituality can take many forms. These discoveries have profoundly influenced my clinical work. The rich, cultural experiences of New Orleans and abroad, as well as my growing passion for the field of psychology, fueled my desire to move to San Francisco to attend graduate school at the California School of Professional Psychology to obtain my doctorate in Clinical Psychology. I had always wanted to live in California and felt that while in a rigorous graduate program it was important to continue to immerse myself in culture and diversity. My clinical experiences were immensely rewarding and reinforced my decision to be a psychologist. After my time in San Francisco, I completed an APA approved pre-doctoral internship program at Louisiana State University Health Sciences Center in New Orleans, Louisiana. While in New Orleans, I provided individual, family, and group mental health services to children, teens, and adults. Shortly after my move back to New Orleans, the city was devastated by Hurricane Katrina. Once I was able to return to the city, I had the opportunity to provide mental health services to residents and first responders who had been displaced by the storm. I have practiced in Georgia since 2006 and have been practicing at Marietta Counseling for Children and Adults, LLC since May of 2009. Currently, I am a member of the American Psychological Association, Association for Play Therapy, and the International Obsessive Compulsive Disorder Foundation (www.ocfoundation.org). I have attended nationally recognized training for the treatment of children, adolescents, and adults with OCD. This specialized training was offered by the country's foremost OCD experts and included current research in OCD. In addition, I regularly consult with other OCD practitioners to remain up to date on treatment. Furthermore, I have received training for the treatment of children and adults who are struggling with Trichotillomania. My GA License Number is PSY003122 and my Occupational Tax Certificate number through Cobb County is 131923.

Please initial that you have read this page _____

I have a strong commitment to my clients and strive to provide a safe and nurturing environment where individuals can achieve their goals and develop healthy coping skills. I am passionate about my work with diagnostically and culturally diverse children, adolescents, adults, and families. I strongly believe in the resilience of families and children. Using evidenced-based treatment, I help my clients achieve their goals at their own pace. I participate in continuing education courses, seminars, and professional conferences in order to stay current and am always expanding on my knowledge base and methodologies in order to best serve the needs of my clients.

About Marietta Counseling for Children and Adults, LLC...

Marietta Counseling for Children and Adults, LLC (MCCA) is a limited liability company in the state of Georgia established to provide a facility where therapists can provide counseling and psychotherapy services for children, adolescents and adults. MCCA provides rental office space to other therapists and confidential peer consultation with other therapists. MCCA affords fully licensed professional counselors and therapists an opportunity to conduct their independent private practices while benefiting from the affiliation with a group of professionals providing services from the same facility. I am affiliated with MCCA but practice under my own tax ID and business license.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit.

Waive Right To Subpoena

In order to protect you and the information you and/or your child(ren) provide to me during our sessions, I ask each client to waive their right to call me as a witness to court for any reason. If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs.

Please initial that you have read this page _____

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) use by therapists and administrative staff employed by or contracting with MCCA for tasks such as consultation, billing, checking voicemail, and making appointments; (2) you direct me to tell someone else and you sign a "Release of Information" form; (3) you verbally or physically threaten me; (4) I determine that you are a danger to yourself or to others; (5) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; (6) The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers, and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act; (7) 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. The state of Georgia 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. Finally, in the event that I die or have a major medical emergency, your file may be accessed by Lynn Louise Wonders, LPC, RYT, Director of Therapy Services at MCCA.

Structure and Cost of Sessions

I agree to provide psychotherapy for the fee of \$200 for the initial session, \$150 per 50 minute session, \$225 per 80 minute session, and/or \$80 per 90 minute group therapy session, unless otherwise negotiated by you or your insurance carrier. This fee includes preparatory work/research, follow up work, and between-session communication with collateral resources. In addition, I will be charging \$100 for any letters or treatment summaries you may need me to write. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at \$2 per minute. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment. For credit card payments, there is an addition \$3 processing fee. I can provide you with a receipt of payment and the receipt 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.

Over the last year I have become a provider for several insurance panels so please ask me about what insurance panels I am on. **In addition, it is your responsibility to check with your insurance company to see if you can utilize your in-network or out-of-network benefits.** Insurance companies have many rules and requirements specific to certain plans. If you are using out-of-network benefits, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. Please have the checks mailed directly to you. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. Please note, that in order to use your insurance benefits, I must give the client an appropriate DSM diagnosis code.

Please initial that you have read this page _____

In an effort to help you with the insurance process, I have delineated some key guidelines below. Following these simple tasks before your first appointment will ensure a greater chance of your claim being reimbursed properly and without delay.

- 1) Give the insurance provider my full legal name, Christina M. Hall. The insurance companies do not have me listed as Christy.
- 2) Check to see if your insurance company participates with MultiPlan/PHCS or Beechstreet. There are not insurance companies, they are PPOs and I am a participating provider with both of these entities. PPOs are basically large groups of doctors or insurance companies that contract together to allow patients greater access to doctors. For example, I am not a Cigna provider, but Cigna now participates with MultiPlan, and many Cigna plans have a MultiPlan logo on the card. If your Cigna card has a MultiPlan logo on it, I might be able take your insurance—even though I do not accept Cigna.

For out-of-network benefits:

- 3) Check with your insurance company to determine whether you need preauthorization to be seen by a provider. If so, make sure to keep copies of any preauthorization documentation or numbers.
- 4) Ask your insurance company if they require claims submissions on a particular type of form.
- 5) Ask your insurance company what **SPECIFIC** information will be needed from the provider of service. This information typically includes the following:
 - Date(s) and time of service
 - Diagnosis Code
 - Service Provided (CPT code)
 - The Provider's Full Name, Credentials, Tax ID Number, and License Number
- 6) If you choose to use out-of-network benefits, give this information to me at your next visit so that I can provide you with the appropriate information and/or required forms (aka: a Superbill).

If you are on one of the panels in which I am a participating provider, please let me know so we can fill out the appropriate paperwork that will allow you to utilize your insurance. ***In addition, you will need to call my billing company, KR Solutions (866.714.1224) to verify your benefits before our first appointment. They will file your insurance claims for you.*** Please be advised that if you agree to file your own insurance claims, my billing company and I **WILL NOT RETRO BILL ANY SESSIONS TO YOUR INSURANCE COMPANY**. If you wish to have our office begin filing your claims on your behalf, we will only file in-network claims from that date forward.

In addition, for those clients who are financially eligible, I do have some reduced fee slots available. Please do not hesitate to talk to me about this. I do not want financial limitations to be a barrier and will do what I can to prevent this. Fees for my services will be due at the end of each session.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions so you will be responsible for what the insurance company pays for individual or family sessions.

Please initial that you have read this page _____

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. Clients are given my office number and I check that voicemail as often as I can. I do not communicate with my clients via email. 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 business 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 Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
- Call 911.
- Go to your nearest emergency room.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as I would like to, for your confidentiality, I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

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 Georgia professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results

Please initial that you have read this page _____

regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. 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 therapist, and you are authorizing me to begin treatment with you.

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.

Christina Hall, PsyD #3122

Date

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ADDENDUM FOR PARENTS OR LEGAL GUARDIANS

Due to the sensitive nature of counseling and the fragile stage of development that your son or daughter is currently experiencing, forming a therapeutic bond with his/her therapist is critical. It is important that he/she feel safe and comfortable discussing personal and private topics with his/her therapist. In effort to respect the privacy and sensitive needs of your son/daughter, I will not be discussing the content of therapy sessions with you (guardian/parent). However, I also recognize the fact that parents need to be involved in the process. Your involvement in the therapeutic process will depend on the age of your child and the presenting problem. Typically, about every 6-8 weeks I can offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. The reason I wait 6-8 weeks is that it gives me chance to assess themes and develop rapport. In addition, I do not provide updates after each session because it is important that the child or teen get as much time during the session as possible to process whatever issues he/she is experiencing. It is critical that the child or teen knows that I am his/her therapist, it is his or her time, and that he/she is not being judged on his/her performance in therapy. However if you need to speak with me about your child's behavior, please call prior to his/her weekly session or arrange a time to come in and speak with me. Parenting and family sessions are common during the treatment process. In addition, we have forms in the waiting room that you can fill out concerning your child's improvement or challenges. It is my hope that through the therapeutic process your child will develop new skills so she/he can discuss these sensitive topics with you in her/his own time. *However, if at anytime I make the assessment that your son or daughter is in danger or might be dangerous to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of your son/daughter, you will be notified immediately so that the necessary actions and precautions can be taken.*

Additionally, as much as you may want to help, it is important not to pressure your son/daughter about what was discussed in session. I do encourage that you always maintain an "open-mind /open-door" attitude and approach. For example: "If you want to tell me about your session, I'm interested in hearing what you have to say, but I understand if you don't want to talk about it." In addition, please do not try to force your child or teen to talk about issues he or she may not be ready to talk about in session. As I mentioned before, it is important that we first develop a trusting therapeutic relationship and that therapy goes at the child's or teen's pace.

I have read and understood the Informed Consent and the Addendum for Parents or Legal Guardians. By signing below I also acknowledge that my son's/daughter's therapist has explained any questions I had about this form.

Parent/Legal Guardian (PLEASE PRINT)

Client Name (PLEASE PRINT)

Parent/Legal Guardian SIGNATURE

Client SIGNATURE

Date Signed

Date Signed

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Health Insurance Portability and Accountability Act (HIPAA)**NOTICE OF PRIVACY PRACTICES***Effective 4/14/03*

I. COMMITMENT TO YOUR PRIVACY: Dr. Hall is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that Dr. Hall maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, Dr. Hall is required to ensure that your PHI is kept private. This Notice explains when, why, and how Dr. Hall would use and/or disclose your PHI. Use of PHI means when Dr. Hall shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when Dr. Hall releases, transfers, gives, or otherwise reveals it to a third party outside of her private practice. With some exceptions, Dr. Hall may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, Dr. Hall is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by Dr. Hall. Please note that Dr. Hall reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that Dr. Hall has created or maintained in the past and for any of your records that Dr. Hall may create or maintain in the future. Dr. Hall will have a copy of the current Notice in the office, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of Dr. Hall's Notice of Privacy Practices.

IV. HOW Dr. Hall MAY USE AND DISCLOSE YOUR PHI: Dr. Hall will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: Dr. Hall may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, Dr. Hall may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, Dr. Hall will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: Dr. Hall may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - Dr. Hall may provide your PHI to its office personnel,

accountants, practice consultants, attorneys and others to make sure that Dr. Hall is in compliance with applicable practices and laws. It is Dr. Hall's practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.

3. To Obtain Payment for Treatment: Dr. Hall may use and disclose your PHI to bill and collect payment for the treatment and services Dr. Hall provided you. Example: Dr. Hall might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. Dr. Hall could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Dr. Hall's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Dr. Hall will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to Dr. Hall by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, Dr. Hall will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of Dr. Hall.

Note: Georgia and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV**, and may limit whether and how Dr. Hall may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES - Dr. Hall may use and/or disclose your PHI without your consent or authorization for the following reasons:

- 1. Law Enforcement:** Subject to certain conditions, Dr. Hall may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Dr. Hall may make a disclosure to the appropriate officials when a law requires Dr. Hall to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- 2. Lawsuits and Disputes:** Dr. Hall may disclose information about you to respond to a court or administrative order or a search warrant. Dr. Hall may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. Dr. Hall will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
- 3. Public Health Risks:** Dr. Hall may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
- 4. Food and Drug Administration (FDA):** Dr. Hall may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- 5. Serious Threat to Health or Safety:** Dr. Hall may disclose your PHI if you are in such mental or emotional condition as to be dangerous to

yourself or the person or property of others, and if Dr. Hall determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Dr. Hall may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. **Minors:** If you are a minor (under 18 years of age), Dr. Hall may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** Dr. Hall may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Dr. Hall has a reasonable suspicion of child abuse or neglect, Dr. Hall will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** Dr. Hall may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Dr. Hall may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** Dr. Hall may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, Dr. Hall may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, Dr. Hall may release PHI about you as required by military command authorities. Dr. Hall may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** Dr. Hall may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, Dr. Hall may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
13. **For Research Purposes:** In certain limited circumstances, Dr. Hall may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** Dr. Hall may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** Dr. Hall is permitted to contact you, without your prior authorization, to provide appointment reminders or

information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

- 16. Health Oversight Activities:** Dr. Hall may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess Dr. Hall's compliance with HIPAA regulations.
- 17. If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization:

In any other situation not covered by this notice, Dr. Hall will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying Dr. Hall in writing of your decision. You understand that Dr. Hall is unable to take back any disclosures she has already made with your permission, Dr. Hall will continue to comply with laws that require certain disclosures, and Dr. Hall is required to retain records of the care she provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in Dr. Hall 's possession, or to get copies of it; however, you must request it in writing. If Dr. Hall does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from Dr. Hall within 30 days of receiving your written request. Under certain circumstances, Dr. Hall may feel she must deny your request, but if she does, Dr. Hall will give you, in writing, the reasons for the denial. Dr. Hall will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than \$.25 per page and the fees associated with supplies and postage. Dr. Hall may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that Dr. Hall limit how she uses and discloses your PHI. While Dr. Hall will consider your request, she is not legally bound to agree. If Dr. Hall does agree to your request, she will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that Dr. Hall is legally required or permitted to make.

3. The Right to Choose How Dr. Hall Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Dr. Hall is obliged to agree to your request providing that she can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that Dr. Hall has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time

period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

Dr. Hall will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Dr. Hall will provide the list to you at no cost, unless you make more than one request in the same year, in which case she will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that Dr. Hall correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of Dr. Hall's receipt of your request. Dr. Hall may deny your request, in writing, if she finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than Dr. Hall denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and Dr. Hall's denial will be attached to any future disclosures of your PHI. If Dr. Hall approves your request, she will make the change(s) to your PHI. Additionally, Dr. Hall will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to Dr. Hall, who is the Director and Privacy Officer, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision Dr. Hall made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. Dr. Hall will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature below indicates that you Acknowledge receipt of this Notice:

Client Name (please print)

Client Signature

Date:

If Applicable:

Parent/Legal Guardian Name (please print)

Parent/Legal Guardian Signature

Date:

Date of Last Revision: 05/01/09

FOR INSURANCE CLIENTS ONLY*PATIENT REGISTRATION FORM*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Telephone #: _____ Alternate Telephone #: _____

Date of Birth: ____/____/____ Social Security No.: ____-____-____ Sex: _____

Marital Status: () Single () Married () Divorced () Separated () Other: _____ Age: _____

Responsible Party: _____ Relationship: _____

Occupation: _____ Work Telephone: _____

Employer: _____

Patients Spouse or Parent (If Minor): _____ Telephone #: _____

Emergency Contact: _____ Telephone #: _____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to **Christina Hall, PsyD** for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize KRD Solutions, LLC (contracted billing service for **Christina Hall, PsyD**) to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize KRD Solutions, LLC to sign said claim(s) or any refiled claim on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: _____ Signature: _____ Date: _____

Insurance Information

Company Name: _____ Telephone #: _____ Policy No.: _____

Group No.: _____ Policy Holder's Social Security No. (if different from Patient): ____-____-____

Policy Holder (if different from Patient): _____ Relationship: _____

TO BE COMPLETED BY BILLING OFFICE

Date: _____ Spoke with: _____ Circle one: In Network Out of Network

Policy Effective: _____ Co pay Per Visit: \$ _____ Coinsurance Per Visit: _____

Deductible Amount: \$ _____ Deductible Met: \$ _____ Max Visits/Max Payable Per Year: _____

Out of Pocket Max Per Year: _____ Exclusions to policy: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Authorization #: _____ Sessions Approved: ____ Authorization Date: _____ thru _____

Notes:

FOR INSURANCE CLIENTS ONLY**Christina M. Hall, PsyD, P.C.**

2440 Sandy Plains Road, Building 13, Suite 300, Marietta, GA 30066

Phone: 770-971-9311 ext. 2

Fax: 866-401-3193

INSURANCE AGREEMENT**(Please read carefully, this is very important!)**

As a service to you, KRD Solutions, LLC will bill your insurance company. Due to the rising costs of healthcare, however, insurance benefits have become increasingly more complex. Although KRD Solutions, LLC is thorough and spends a great deal of time ascertaining your benefits at the forefront as well as filing your claims accurately, we still cannot guarantee that your insurance company will follow through with their original statement of benefits. In some cases, insurance companies have been known to change benefits in the middle of a policy year without notification to the provider. In other cases, session visit limits, deductibles, or maximum allowables may vary from those originally quoted, thereby altering or altogether preventing claims from paying in accordance with the benefits the provider has on file. Therefore, it is the responsibility of the client to keep in contact with their insurance provider concerning their mental health benefits (co-pays, deductibles, number of sessions available). In addition, it is my policy to have a credit card on file for each client planning to use insurance, as well as a photocopy of the credit card holder's driver's license. Please know that I will only charge your card as last resort and I will attempt to notify you first. Also, there is a \$3 processing fee for using a credit card. However, if you feel strongly about not keeping a credit card on file, you have one other option listed below. Please place a check mark next to the option that you prefer:

- Credit Card Option:** I would like Dr. Hall to collect only the deductible and the percentage that I'm required to pay according to my insurance company after each visit. As a courtesy, KRD Solutions, LLC will then file my claim for me in order for Dr. Hall to receive the remainder of the payment due. Occasionally, insurance carriers elect not to pay a claim for one reason or another. In the event that this happens or if I cancel my appoint with less than 24 hours notice, I authorize Dr. Hall to charge my credit card for the remaining balance, plus \$3 for the processing fee.

Credit Card Information Required:

Name as it appears on your card: _____

Credit Card Number: _____

Exp. Date: _____ Security Code (last three or four numbers on the **back** of your card): _____Credit Card Billing Information: _____
Street Number (street name not required) Zip Code

Client Signature: _____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Alternative Option: I would like Dr. Hall to provide me with a receipt for services (also known as a “Superbill”) that will serve as documentation for my insurance company to receive reimbursement. I realize I am required to pay for therapy in full at the time of service. I also understand that my insurance company will reimburse me directly.

Additionally, it is my ethical obligation to be sure that you are aware of the following information regarding insurance companies. Most insurance companies require mental health practitioners to disclose certain information about their clients in order to receive benefits. First and foremost, they always require a diagnosis. Frequently, they require additional information to justify ongoing treatment. This information includes physical health concerns you may have, psychosocial stressors (such as problems in relationships, work, etc.), and your general level of functioning. Insurance companies often require treatment plans, and they occasionally require copies of the therapist’s notes. It is my policy to protect your confidentiality by providing only the information that is absolutely necessary. All of this information will become part of the insurance company’s records and is usually stored in a computer database.

I have a 24-hour cancellation policy. Since insurance companies do not pay for missed sessions, you will need to pay for the full amount of your session rather than just your co-pay. If you cancel an appointment with me with less than 24 hours notice, you will be financially responsible for the complete balance for the session. If necessary, the card you provided above will be used to collect that balance. Additionally, it is your responsibility to make sure that I always have the most up to date information on file regarding your insurance company as well as your most up to date contact information.

I have read the above policies, and I accept this Insurance Agreement.

Client’s Name (Please Print)

Client Signature

Date

Christina M. Hall, PsyD, P.C.

2440 Sandy Plains Road, Building 13, Suite 300, Marietta, GA 30066

Phone: 770-971-9311 ext. 2

Fax: 866-401-3193

Credit Card Policy

If you wish to use a credit card rather than check or cash there will be a \$3.00 convenience fee added to your session balance and charged to your account. I require all clients to provide a credit card to keep on file as well as **a photocopy of the credit card holder's driver's license**. Your credit card will be charged if you miss an appointment without canceling within the 24-hour cancellation policy time frame and the \$3.00 convenience fee will be added to the missed appointment fee. Also, please know that I can only charge a maximum of two sessions for each credit card transaction.

I agree to the terms of credit card usage as explained above.

Printed Name: _____

Signature _____

Date: _____

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Christina M. Hall, PsyD, P.C.

2440 Sandy Plains Road, Building 13, Suite 300, Marietta, GA 30066

Phone: 770-971-9311 ext. 2

Fax: 866-401-3193

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, _____ (client), hereby authorize
_____ (therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

- (1) _____
- (2) _____
- (3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

Additionally, the above named parties, therapist & person(s) or entity (entities) designated under (1) or (2) or (3), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at: 2440 Sandy Plains Road, Building 13, Suite 300, Marietta, GA 30066 to be effective.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

Directions

From I-75: Exit 267A. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons Neighborhood and Mozelle St. Just past Mozelle St you will pass a graveyard on your right you will see a sign for Edwards Jones Investment. At the Edward Jones sign, turn right into the office park. Go to the first stop sign and turn right. Building 13 is on your right.

From Barrett Parkway: Travel southeast on Barrett. It will turn into East Piedmont. As you approach Sprayberry H.S. on your right you will turn right onto Sandy Plains Road. Turn left at the break in the median onto First Street and then take an immediate right into the office park. Building 13 will be down on the right.

From East(er) Cobb: Travel East Piedmont off of Sewell Mill or 120 heading northwest until you come to Sandy Plains Rd. Turn left at the break in the median onto First Street and then take an immediate right into the office park. Building 13 will be down on the right.

From Woodstock and Roswell: From 92 take Sandy Plains Road west to East Piedmont. Cross over East Piedmont. Turn left at the break in the median onto First Street and then take an immediate right into the office park. Building 13 will be down on the right.

From West Cobb: From Marietta Square make your way toward Kennestone Hospital passing Kennestone on your left and crossing over I75 on Canton. At first light you will turn right onto Sandy Plains Rd. Go through 5 stoplights. Pass Keswyck Commons Neighborhood and Mozelle St. Just past Mozelle St you will pass a graveyard on your right you will see a sign for Edwards Jones Investment. At the Edward Jones sign, turn right into the office park. Go to the first stop sign and turn right. Building 13 is on your right.