

**Jennifer M. Keith, Psy.D.**  
**Psychoeducational/Psychological Assessment Agreement**

Welcome to my practice. This document contains important information about my professional services and business policies with regard to assessment. Please read it carefully and let me know if you have any questions. Please acknowledge your understanding of this policy by signing at the end of this form.

**Psychological/Psychoeducational Assessment:** Psychological or Psychoeducational Assessment varies depending on the reason for referral. In all cases, the assessment process will include a battery of psychological measures as well as a clinical interview. Depending on the purpose of the evaluation, a battery of tests may include measures that assess cognitive abilities, achievement, memory, attention, and/or emotional and psychological well being. The number of tests and the length of the evaluation are dependent upon the reason for referral. The measures are administered by me and will likely be a combination of interactive and questionnaire type tests. The selected measures are widely used tests that have been shown to have good reliability and validity with regard to the reason for the evaluation. In addition, the tests are also selected for appropriateness with regard to age and educational attainment.

**Professional Fees:** My hourly fee is \$150.00 per hour for assessment sessions. This includes report writing, feedback sessions, and any additional feedback provided to a third party. Some insurance companies will provide reimbursement for certain testing procedures related to psychological testing. Most insurance companies will not provide reimbursement for educational testing. It is the responsibility of the patient or his/her parent or guardian to provide payment for testing services not covered by the insurance carrier. If you choose to use insurance, a pre-authorization is usually required. It is very common for insurance companies to pay differently than what they quoted you at the time of the first visit or deny coverage at a later date. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Any balances unpaid after 60 days are subject to a 1.5 % per month finance charge. Payment in full is expected at the time of service. Please inform me if there are exceptional circumstances prior to the first session.

Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. **Appointments not canceled with at least 24 hours notice will be billed at the usual fee of \$150.00 per reserved hour. Monday appointments must be canceled by 12:00 noon the Friday before to avoid charges.** It is important to note that insurance companies do not reimburse for missed or late canceled sessions, so the full \$150.00 fee will be your responsibility.

**Statement of Confidentiality:** Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. In most situations, I can only release information about your treatment to others (third party) if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to self, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you first.

**Agreement:** I acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including attorney's fees. I have read and understand the above policies.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature of minor

\_\_\_\_\_  
Parent or Guardian Signature of Minor  
(Both parents must sign if joint custody)

\_\_\_\_\_  
Date

**Patient Information:**

NAME: \_\_\_\_\_  
                    First                                    Middle                                    Last

ADDRESS: \_\_\_\_\_  
                    Street                                    City                                    State                                    Zip

PHONE: \_\_\_\_\_  
                    Home                                    Work                                    Cell

SOCIAL SECURITY #: \_\_\_\_\_ SEX: \_\_\_ Male \_\_\_ Female

MARITAL STATUS: S M D W DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ POSITION: \_\_\_\_\_

Can a message be left at Home? \_\_\_ Yes \_\_\_ No Work? \_\_\_ Yes \_\_\_ No Cell? \_\_\_ Yes \_\_\_ No

REFERRED BY: \_\_\_\_\_ May I contact this person? \_\_\_ Yes \_\_\_ No

Have you been in therapy before? \_\_\_ Yes \_\_\_ No For your current problem? \_\_\_ Yes \_\_\_ No

If so, Where? \_\_\_\_\_ When? \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  
                    Work                                    Home                                    Cell

**Responsible Party/Spouse/Parent Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Insurance:**

Name of carrier: \_\_\_\_\_ Name of insured: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Patients: Please read and sign the following assignment of benefits if you would like me to file insurance for you.**

**Assignment of Benefits**

I authorize Dr. Jennifer Keith to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Dr. Jennifer Keith for services rendered. I accept personal responsibility for any balance remaining for services rendered including those that may be determined "not medically necessary" by my insurance carrier or denied coverage for any reason. I may receive a bill for services rendered if my insurance company does not reimburse as anticipated or requests a refund for previously paid services. I acknowledge responsibility for all fees incurred and, if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including court and legal fees.

\_\_\_\_\_  
Patient/Parent or Guardian Signature

\_\_\_\_\_  
Date

**Primary Care Physician Information:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

How long have you been a patient of this physician? \_\_\_\_\_

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, I \_\_\_\_\_ give permission to \_\_\_\_\_  
to send a general statement notifying my primary care physician of my visit today. The information sent  
will be used for coordination of care, and will be limited to a brief description of the problem area and/or  
diagnosis, and a general outline of treatment.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date