Walter B. Branch, Ph.D.

Savannah Psychological Specialists, LLC

www.savannahpych.com
email: savannahpsych@gmail.com

1980 Chatham Parkway, Suite 701
Savannah, Georgia 31405
Voice: (912) 777-5761
Fax: (912) 777-5762

Consent for Psychological Services
Read and Sign BEFORE you arrive for your appointment.

We are looking forward to seeing your son or daughter. These forms will help make your visit as comfortable as possible and inform you of our office policies and procedures. Dr. Branch sees children and adolescents; he does not see adults. Dr. Branch does not do custody or visitation work. Dr. Branch does not do any type of legal work. Dr. Branch does not get involved with DFCS placement issues. Dr. Branch does not prescribe medication.

We make every effort to keep on time. If you arrive late, your appointment time will be shortened. If you do not fill out these forms completely before you arrive, your appointment time will be shortened. You should be completely ready to see Dr. Branch at your appointment time. If you decide that you do not want to keep an appointment, please call to cancel the appointment so we may give the time to someone else. Please bring your insurance card and these forms (completed) with you.

Office hours are Monday - Thursday 9:00-1:00; 4:00 - 6:00. The office is closed on Friday, Saturday and Sunday. If you arrive too late to be seen, you will be rescheduled. If you need to call the office, the office manager is available until noon. Before noon is the best time to call.

Confidentiality between psychologist and patient is guaranteed by Georgia law except under certain circumstances. For example, psychologists are required to report suspected child abuse. Unless ordered so by a judge, Dr. Branch treats both parents in cases of divorce as if both had legal guardianship. In cases of divorce, Dr. Branch does not take sides. Dr. Branch will not go to court and testify against your ex-spouse. If a child is referred to Dr. Branch from a physician or other health care professional, it is understood that Dr. Branch may send a copy of the report and/or office notes to the health care professional. You give consent for SPS, LLC to leave messages regarding your care or appointment reminders on the phone number(s) you have provided to SPS, LLC. Please read and sign the enclosed HIPPA notice.

The fee for your first visit is $150.00. This is what you are expected to pay if you have not met your insurance deductible and will be collected when you arrive for the appointment. If you have a copay, it will be collected when you arrive for the appointment. We accept cash, checks, money orders and credit cards. Psychological testing and evaluation are separate fees. In cases of divorce we expect payment from the parent who brings the child to the appointment, regardless of what your divorce decree may say.

Please understand that we cannot guarantee or be responsible for your insurance coverage. Insurance coverage varies depending upon your policy. Full payment of charges for professional services is your responsibility. The bill is yours, not your insurance company. We turn over un paid accounts to an outside collection agency. If your insurance changes and you do not let us know before you arrive for an appointment, you may be responsible for paying for that date of service.

Some insurance policies require Dr. Branch to get a procedure such as psychological testing preauthorized. We have to do this before the testing is done. An insurance company can also decide to not authorize a procedure. When an insurance company authorizes testing, they are simply saying that are authorizing testing. They are not saying that they will necessarily pay for it.

If after your first visit you do not call to cancel an appointment you WILL BE CHARGED a fee of $20.00, which must be paid before any future appointments are made. If you call to reschedule, it will probably be several weeks before you can be seen. If you have two missed visits, you will not be rescheduled.

Make sure your voicemail is set up and is not full. We can not leave you a message if your voicemail is not set up or it is full.

It is important that you understand your health insurance policy. This form will help you understand your insurance policy. The charge or bill for professional services is to you, not your insurance company. As a courtesy, we will file a claim with your insurance company but we do not bill your insurance company. The bill is yours. The charge for your first visit is $150.00. Please be prepared to pay this when you arrive, unless you have already met your deductible, in which case please be prepared to pay your copay. (This paragraph does not apply to Medicaid).

Check how you will be paying for your first visit:

___ Cash, Check or Money Order.

___ Credit Card.

We strongly urge you to contact your health insurance company regarding your mental health benefits before you arrive for your first appointment. (Does not apply to Medicaid or Tricare). Most insurance companies treat mental health benefits differently from medical benefits.

Among the questions you should ask are:

Do I have mental health benefits? _____

Some insurance companies "farm" their mental health benefits to another company. Anthem does this a lot. Are mental health benefits handled by another company? _____

If mental health benefits are handled by another company, what is the name of the company _____

What is the phone number for the company? _____

What is the patient ID for the company? _____

Is Dr. Branch a provider with my insurance company? _____

What is my copay? _____

What is my deductible? _____

How much of my deductible has been met? _____ (Note: If your deductible has not been met, you will have to pay $150.00 for the first visit).

Is the first visit (90791) covered? _____ Does it require preauthorization? _____

These are the CPT codes we use for testing. You can ask your insurance company if they cover these codes: 96130, 96131, 96136, and 96137. Do they require pre-authorization? _____

Please sign below acknowledging that you have read and understood this Consent form. If you have any questions, please do not hesitate to call.

_____

Child's Name

_____ *Date:* _____

Parent or Legal Guardian

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www.savannahpsych.com
www.drwalterbranch.com
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Patient Demographic Information

Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

School: _____ Grade: _____

Parent Information

Mother's Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Father's Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Insurance Information

Primary Insurance

Name of Insurance Company:_____
Policy #: _____ Group #: _____

Name of Insured: _____ ID or SS#: _____

Secondary Insurance

Name of Insurance Company: _____
Policy #: _____ Group #: _____

Name of Insured: _____ ID or SS#: _____
Emergency Contact

Please indicate an emergency contact person.
Name: _____Relationship to Child: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____

We usually make a courtesy reminder call the day before your visit(s). The number we call is the one in our computer. If your phone number changes, please let us know. Regardless of whether a courtesy call is made, you are still responsible for keeping any visits you have scheduled.

Any special instructions you may need to tell us?

If you have any questions about these forms, please call.

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Patient Clinical Information - Please answer all the questions. **DO NOT leave any questions blank.**

Child's Name: _____ Age: _____ Date of Birth: _____
Who referred you to us? _____
With whom does this child live: _____
Ages and sex of siblings: _____

School Problems:
Name of school: _____ What grade is this child in? _____
What grades does this child make? _____
Describe any attention span problems:_____
Is this child hyperactive in school? _____
Describe any behavioral problems in school:_____
Describe any oppositional/defiant behavior in school: _____
Describe any social skills problems: _____
Which grades has this child repeated? _____
Has the school psychologist tested this child? _____ When:_____
Is this child receiving Section 504 services? _____
Is this child receiving special education services?_____

Home Problems:
Describe any problems with attention span: _____
Describe any problems with hyperactivity: _____
Describe any homework problems: _____
Describe any behavioral problems at home: _____
Describe any oppositional/defiant behavior at home: _____
Describe any anger control problems: _____
Describe any temper tantrums: _____
Describe any problems in public places: _____
When does this child have crying spells? _____
Describe any social skills problems: _____
Are there any problems getting to sleep? _____
Does this child wake up a lot at night after he or she gets to sleep? _____
How often does this child have bad dreams? _____
Describe any appetite problems: _____
Does this child seem sad or depressed? _____
Does this child seem anxious or nervous? _____
Describe any suicidal thoughts or behaviors? _____
Describe any self-harm behavior: _____
Has this child had any confirmed history of physical or sexual abuse? _____
Describe any sensitivities to sounds, clothing or textures of food? _____
Describe any auditory or visual hallucinations: _____
What are this child's interests and activities: _____

Developmental History:

Describe any pregnancy or delivery problems _____

Birthplace _____ Birthweight _____ Age of first words: _____ Age of first steps: _____

Describe this child's personality as a toddler and preschooler? _____

_____

Describe any history of neurological problems?_____

Any history of speech or language therapy, OT or PT? _____ When? _____

Describe any hearing or vision problems?_____

Any prior psychological testing? If yes, who did the testing and when was it done?_____

_____

_____

Any prior psychological counseling? If yes, with whom and when? _____

_____

Please describe any family history of psychological problems? _____

_____

Any involvement with the police or Juvenile Court? _____

_____

Describe any medical problems: _____

_____

What medications is this child taking _____

_____

Does this person abuse illegal drugs? Which ones? _____

Who is this child's pediatrician? _____

What is your greatest concern regarding this child? _____

_____

_____

_____

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FINANCIAL RESPONSIBILITY

Savannah Psychological Specialists will file your insurance claim and make all reasonable efforts to collect reimbursement from your insurance company. However, this does not release the parent, guarantor, or responsible party from financial responsibility. The bill belongs to you, not your insurance company. If, for some reason, claims are not paid by the insurance company, then it is your responsibility to pay for professional services. In all cases, payment of the copay, deductible and/or co-insurance portion of the bill should be made at the time of service. In cases of divorce we expect payment from the parent who brings the child to the appointment, regardless of what your divorce decree may say.

THEREFORE

I understand that I am responsible for payment for services rendered by Savannah Psychological Specialists. I understand that unpaid accounts are turned over to a collection agency. If a check is returned by the bank as NSF, the bank fee will be added to my bill.

_____ _____
Signature of Parent or Responsible Party Date:

RELEASE AND ASSIGNMENT

I authorize the release of necessary information to process my insurance claims. I also authorize assignment of all benefits to SPS/Dr. Branch. I understand that if my insurance company has any other insurance on record, and I actually do not have that insurance, my insurance company may not reimburse Dr. Branch for services he performs and I will be completely responsible for the bill. I also understand that if my child's insurance is not active on the date of service, then I will be completely responsible for paying the bill.

_____ _____
Signature of Parent or Responsible Party Date

MISSED APPOINTMENTS

I understand that I will be billed $20.00 for any appointment which is not canceled in time to fill it from the waiting list. I also understand that insurance companies can not be billed for missed appointments. Payment for a missed visit must be made before any future appointments are scheduled.

_____ _____
Signature of Parent or Responsible Party Date

CONSENT

I consent, agree, and authorize evaluation and/or treatment by Savannah Psychological Specialists. I have read and signed the the HIPAA notice.

_____ _____
Signature of Parent or Responsible Party Date

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Finding Savannah Psychological Specialists

From Downtown Savannah. Chatham Parkway Office: Take I-16. Exit onto Chatham Parkway. Turn right and go over I-16. Go through the intersection at Hwy 17 (McDonald's is on the right). Turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back, left side - Suite 701.

From Midtown Savannah - Take DeRenne toward 516. Exit right onto Veterans Parkway. Exit onto Chatham Parkway then take an immediate right at the Seed Church. (Redgate will be on the left). There are three buildings in front of the church. Our office is the back building, left side - Suite 701.

From Southside Savannah/Georgetown/Ellabell (and Beaufort, SC) - Drive down GA 204/Abercorn. Get onto Veteran's Parkway (the "flyover" near the Forest River bridge). Exit right at Chatham Parkway entrance ramp. Turn left onto Chatham Parkway. Drive only a few feet, then take the first right at the Seed Church. (Redgate will be on the left). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Richmond Hill - Drive down Hwy-17 until it intersects Chatham Parkway. Turn right onto Chatham Parkway (McDonald's is on the left). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Pooler and Bloomingdale - Drive down I-16 or Hwy 80 until it intersects Chatham Parkway. Exit right onto Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Port Wentworth - Drive down 516 to Veterans Parkway. Take Veterans Parkway exit to Chatham Parkway. Turn right onto Chatham Parkway, then take an immediate right at the Seed Church (Redgate will be on the left). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From the North end, drive down I-95 until it intersects I-16. Take I-16 to Chatham Parkway. Exit right onto Chatham Parkway. Drive down Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Garden City - Drive down Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From South Carolina (Hilton Head) - Drive over the Talmadge Bridge and stay on I-16. Exit onto Chatham Parkway. Keep right. Continue on Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three building in front of the church. Our office is in the back building, left side - Suite 701.

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We are required by Federal Law to give you
this form to read and sign. Thank you for your assistance in this matter.

GEORGIA NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  -- Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  -- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  -- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business- related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- Adult and Domestic Abuse - If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- Health Oversight Activities - If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety - If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Worker's Compensation - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process

- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with the revision at your next appointment.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact your treating psychologist at 912-777-5761.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to Dr. Walter B. Branch, 1980 Chatham Parkway, Suite 701, Savannah, GA 31405 or via e-mail savanahpsych@gmail.com

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2014.

I have read the Georgia Notice Form provided by Savannah Psychological Specialists.

_____ _____

Name Date