Dr. David Raque Ph. D.
Licensed Psychologist
9757 Blue Ridge Drive, Blue Ridge, GA 30513
11 Lenox Pointe, N.E., Atlanta, GA 30324
(706) 455-2492/(404) 233-0660

Client Information

Client _____ **Age** _____ **Sex** _____ **Date** _____

Address _____ **DOB**_____
Street

_____
City **State** **Zip**

Name of Insured _____**Relationship** _____

Social Security Number _____ _____
Responsible Party

If I should need to contact you, where could I reach you?

Home Phone_____ **Cell** _____ **Work**_____

If I need to contact someone on your behalf in an emergency, whom should I call?

_____

_____

Who referred you to this facility_____

I request that payment under the medical insurance program be made on my behalf to Dr. David Raque for any services provided. I authorize Dr. David Raque to release any medical information about my child to the Health Care Financing Administration and its agents in order to determine these benefits.

_____ **Date** _____
Signature

NOTE: If unable to keep an appointment, kindly give 24 hours notice. It is common practice to charge for therapy hours not kept and not cancelled within 24 hours notice. PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. FAILURE TO DO SO MAY RESULT IN TERMINATION FROM THE PRACTICE.

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Intake Form

Today's Date:_____

Your Name:_____

Birth date:_____

Home phone:_____ **Work phone:_____**

Cell phone:_____ **Email:_____**

Home Address:_____
Number and Street

_____
City, State and Zip

Mailing Address, if different from above:_____
Number and State

_____
City, State and Zip

Which phone number, email or address do you give permission to receive a message, email, or other correspondence?_____

Highest Education Received: _____

Occupation: _____

Relationship Status:

_____ Single **____ Widowed/Date:_____**

_____ Married/Date: _____ **____ Divorced/Date: _____**

_____ Living with Partner/Date: _____ **____ Remarried/Date:_____**

_____ Separated/Date: _____ **____ Other/Date: _____**

Name of Spouse/Partner:_____

Birth date:_____

Home phone:_____ **Work phone:**_____

Cell phone:_____ **Email:**_____

Address:_____

Number and Street

_____

City, State and Zip

Names of children (if any):

1. _____ **Birth date:** _____

2. _____ **Birth date:** _____

3. _____ **Birth date:** _____

4. _____ **Birth date:** _____

Local person to contact in the event of an emergency:

Name: _____ **Relationship:** _____

Phone Number: _____

Family Doctor: _____ **Phone:** _____

Please list any illnesses or medical conditions: _____

_____

_____

Are you currently taking any medications? _____ yes _____ no

If yes, what and for what condition(s)?: _____

_____

Have you ever, or are you currently involved in any kind of therapy, counseling, or other mental health treatment at another setting or clinic such as (please check all those that apply):

____ marital therapy

____ family therapy

____ individual therapy

____ group therapy

____ in or out patient treatment for drugs or alcohol

____ in or out patient therapy for a eating disorder

____ in or out patient therapy for any psychological or emotional issues

Where was this treatment and with whom? _____

When? _____ Was the experience helpful? _____

In what way was the experience either helpful or not? _____

Your reason for seeking therapy today:_____

Please check any of the boxes that you are concerned about or would like to discuss:

_____ accident or injury
____ addiction
____ alcohol or drugs
____ anger
____ anxiety
____ bereavement
____ career goals
____ children
____ chronic illness
____ communication
____ conflict resolution
____ depression
____ disturbing or troubling thoughts
_____ divorce or separation
____ eating concerns or disorder
____ faith
____ financial concerns
____ gender identity
____ grief
____ hopelessness
____ infertility
____ in-laws
____ insomnia
____ job
____ loss of loved one
____ marriage difficulties
____ men's issues
____ motivation
____ parenting
____ pregnancy
____ relationships
____ school difficulties
____ self-esteem
____ sexual difficulties
____ special needs
____ spirituality
____ stress
____ suicidal thoughts
____ trauma
____ weight
____ women's issues

What do you hope to accomplish in therapy?_____

Is there anything else that you would like me to know before we begin? _____

Name of person who referred you to our office? _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, (name of patient)_____, (hereinafter "Patient") hereby authorize David Raque, Ph.D. (hereinafter "Provider) to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

_____

_____

I undertand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at: 11 Lenox Pointe, N.E., Suite B, Atlanta, Georgia 30324, to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:_____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until:_____

Patient's signature:_____ Date:_____

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EXPLANATION OF INSURANCE BENEFITS

Client Name_____ Date _____

Address_____ Age _____ Sex _____

Phone _____ Cell Phone _____

Name of Insured_____ Social Security _____

Responsible Party _____ Relationship _____

If Copy of Insurance Card is Provided, Information Below Is Not Required

Insurance Company _____ Phone _____

Policy Number _____ Group Number_____

Address _____

Benefits for Outpatient Mental Health _____ IN-Network _____Out-Network

Deductible: Amount and when began_____

Does Deductible apply to outpatient Mental Health Specialist Visit_____

Co-Pay _____ Prior Authorization Needed_____

Number of visits per Year _____ Amount per Visit _____

CPT CODES: 90791 _____ 90834 _____ 90837 _____ 90847_____

What is your EDI (Electronic Data Information/Payer ID)_____

Additional Comments_____

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral heath provider to share valuable information with your PCP.

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PAYMENT POLICY:

The following payment polices are in effect as of December 1, 2015:

FEES

Dr. David Raque's fee is $185 per 55 minute hour.

1. **Client accepts full financial responsibility for payment on all services Rendered, including fees not paid by insurance company.**

2. **Cancellations made within 24 hours of the scheduled appointment and/or no-shows will be subject to a full charge.**

3. **For anyone with Medicaid or Medicare coverage, a $50.00 charge will be assessed for cancellations made within 24 hours of a scheduled appointment and/or for no-shows**

By signing, I certify that I have read the above agreement, that I understand it, and that I will adhere to it. My therapist has answered, to my satisfaction, all questions I have about these matters.

I hereby acknowledge that payment is expected at the time services are rendered. Failure to do so may result is my termination from this practice.

Signed _____ **Date** _____

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name	Phone Number
Dr. David Raque, Ph.D.	706-455-2492

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Last Updated: 01/10/06

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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 healthcare. 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 activates 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 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 heath care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization 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 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.

II Uses and Disclosure 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.

III 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 notify you in writing by mail or in person.

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 Dr. David Raque Ph. D.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint.

You may also send a written complaint to the Secretary of the U.S, Department of Health and Human Services. The person Listed about can provide you 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 March 1, 2007

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing.

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Clients Rights and Information

Effective communication between the client and the therapist is an important part of the therapy process. The following information covers many of the questions that may arise about therapy and includes a listing of the client's rights and the therapist's obligations. Any questions you may have that are not covered may be brought to the attention of your Therapist.

Clients Seeking Psychological Services
Have the Right to Know the Following Information:

1) **Information about the availability of the therapist. Clients are invited to inquire about: When the therapist is available and where to call during off hours in case of emergency.**

2) **Information about the structure of the therapeutic relationship. Clients are invited to inquire about:**

   ***The manner in which the therapist conducts sessions concerning intake, treatment and termination. Clients may take an active part in their therapeutic process by asking questions about issues relevant to therapy, specifying therapeutic goals and renegotiating goals when necessary.**

   ***The perspective(s) the therapist typically utilizes to structure intervention and alternative methods of treatment.**

   ***The purpose of the Risks involved in psychological intervention. Clients may refuse any intervention or treatment strategy.**

   ***The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.**

   ***The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consultation with another therapist.**

3) **Information about the fees and billing arrangements. Clients are invited to inquire about:**

   ***The amount of the fee**

   ***The time frame for payment**

   ***The method of payment including fee for service and insurance reimbursement**

   ***The access to billing statements**

   The billing for missed appointments and late cancellations

Client Signature_____ **Date** _____

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4) **Information about the status of the therapist, including the therapist's training, credentials, and years of experience.**

5) **Information about informed consent and exceptions to confidentiality. Clients are invited to inquire about:**

***the circumstances under which confidentiality is limited are outlined below.**

+ The therapist's duty to warn another in case of potential suicide, homicide or the threat of imminent, serious harm to another individual.

+The therapist's duty to report suspicion of abuse or neglect of children and vulnerable adults.

+The therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, and amphetamine or their derivatives.

+ The therapist's duty to report the misconduct of any other health care professionals.

+The therapist's duty to provide to a spouse or the parents of a deceased client access to their child's or spouse's records.

+The therapist's duty to provide to parents of minor children access to their children's records. Minor clients can request in writing the particular information is not disclosed to parents. Such a request should be discussed with the therapist.

+The therapist's duty to release records if subpoenaed by the courts.

6) **Information about counseling records. Clients are invited to inquire about:**

+the maintenance of records, including the security and length of time they are kept.

+ the client's right to access personal records.

+The release policies and procedures.

Client Signature _____ **Date** _____

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Your signature below indicates that you have taken the Psychotherapist -Patient Services Agreement document, agree to read it, and abide by it, and abide by its terms during our professional relationship.

Your signature also indicates that you have received the Georgia Notice of Health Information Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Signature _____ **Date** _____