

LINDA OLSON, Psy.D.

New Patient Information

The following information pertains to my financial policy. I hope this will answer any questions you may have, but if you do have any questions or special concerns please do not hesitate to discuss them with me **at the first session**. Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy of this form for your records I will be happy to provide one for you.

1. My fee is **\$175.00** per therapy hour and **\$190.00** for couples or family sessions, **payable at the end of each session**. The usual therapy hour consists of 45-50 minutes. The fee for the initial diagnostic session is **\$200.00**. Charges for consultations outside the usual therapy hour (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis.
2. Payment is expected at the end of each session. **Please discuss exceptional circumstances with me at the first session**. Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. However, I will file insurance on your behalf. After the office manager verifies your insurance eligibility and level of benefits, I will gladly accept only the co-payment. Until that time, please plan on paying the full amount. My office verifies insurance benefits in an attempt to obtain accurate information regarding your co-payment and/or deductibles. However, it is very common for insurance companies to pay differently than what they quoted at the time of your visit. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated. If your managed care company requires authorization for our sessions, I will complete all necessary paperwork to obtain them. However, my office cannot adequately track number of sessions used for each authorization. Therefore, to avoid any disruption in your reimbursement, it is your responsibility to monitor the number of sessions we have used and to notify me when we are about to exceed those authorize. I can submit additional clinical information to obtain more sessions.
3. 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 **\$175.00 or \$190.00**. **Missed appointments cannot be billed to the insurance company**. You may leave a message with my answering service after hours and on weekends if you need to cancel an appointment. Full Slate, the calendar I use, will email 72 hrs., 24 hrs. in advance to remind you. If it fails to do so you still bear responsibility to cancel.

Statement of Confidentiality: Confidentiality is protected as described in HIPAA regulations (See Attached). Under Georgia law communications between patients and psychologists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. However, there are three clear exceptions in which a psychologist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to himself or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, and (3) actual or suspected incidents of child or elder 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.

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's Signature

Date

Parent or Guardian's Signature of minor

Date

LINDA OLSON, Psy.D.

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

Assignment of Benefits

I authorize Linda Olson, PhD. to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Linda Olson, PhD. 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.

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

LINDA OLSON, Psy.D.

Patient Information:

NAME: _____
 First Middle Last

ADDRESS: _____
 Street City State Zip

PHONE: _____
 Home Work Cell E-mail

Can a message be left at Home? YES or NO
 Work? YES or NO
 Cell? YES or NO

SOCIAL SECURITY#: _____ SEX: Male Female

MARITAL STATUS: M S D W DATE OF BIRTH: _____ AGE: _____

EMPLOYER: _____ POSITION: _____

Are you seeing another therapy? YES or NO For your current problem? YES or NO

If so, Where? _____ When? _____

Emergency Contact: _____ Phone #: _____

Address: _____

Responsible Party/Spouse/Parent Information:

Name: _____ Date of Birth: _____ SS #: _____

Phone: _____
 Work Home Cell

Primary Insurance:

Name of Carrier: _____ ID#: _____ Group #: _____

Name of Insured: _____ Phone #: _____

Secondary Insurance:

Name of Carrier: _____ ID#: _____ Group #: _____

Name of Insured: _____ Phone #: _____

LINDA OLSON, Psy.D.

Intake Form

Date of first appointment: __/__/__

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- Website at www.CLIENTWEBSITE.com
- Psychology Today website
- Friend/Family: _____

Have you previously received any type of mental health services? No Yes

If yes, which of the following:

- psychotherapy medication outpatient hospitalizations inpatient hospitalization

Please provide:

Name of provider or facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today?

When did your problem first start? Within the last:

- 30 days 6-12 months 2 years During adolescence During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- No Yes If yes, when did you begin experiencing this? _____

LINDA OLSON, Psy.D.

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were, you born? _____

Where did you grow up? _____

- city suburbs country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they now live?	If deceased, age and cause of death

Who did you live with, growing up? _____

Mother's occupation: _____

Father's occupation: _____

LINDA OLSON, Psy.D.

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no: which was---	

Marital Status:

- Never Married
- Domestic Partner Married For how long? _____ Please give partners name: _____
- On a scale of 1-10 (best), how would you rate your relationship? _____
- Separated Divorced For how long? _____
- Widowed: please give partners name, and year deceased: _____

Are you currently in a romantic relationship? No Yes If yes, for how long? _____
 On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

LINDA OLSON, Psy.D.

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

Please list any difficulties you experience with your appetite or eating patterns:

Any change in weight over the past year? No Yes: _____

Are you currently experiencing any chronic pain? No Yes

If yes, please describe _____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

LINDA OLSON, Psy.D.

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? No Yes
If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?