Dr. John W. Wilson, Psy.D.
Licensed Psychologist

2250 N. Druid Hills Rd, Ste 233
Atlanta, GA 30329
(404) 246-1257

IDENTIFYING INFORMATION

Name: _____ Gender: _____

Address: _____ Race/Ethnicity: _____

_____ Sexual Orientation: _____

Email Address: _____. Phone Number: _____

Age: _____ Birthdate: ____/____/____

Emergency contact name/phone #: _____ Relationship: _____

Who referred you to my office? _____

PRIMARY INSURANCE (complete only if you have Aetna insurance)

**All information in this block pertains to the primary cardholder and may or may not be the patient.*

Primary Card Holder: _____ Birthdate ____/____/____

Relationship to Client: _____ Telephone: _____

Address: _____

Insurance Plan Name: _____. Benefits & Claims Phone: _____

Member ID # _____ Group ID # _____

EDUCATION HISTORY

Highest level of education: _____ Typical grades: _____

Have you ever repeated a grade: _____ Special Education classes? _____

SOCIAL HISTORY

Where were you born? _____ Where were you raised? _____

Mother's Occupation: _____ Father's Occupation: _____

Any history of childhood abuse*? Y N* If yes, which type of abuse? *Physical Verbal Emotional Sexual*

Relationship Status?: *Single Dating Married Partnered Divorced Separated Widowed*

Siblings (gender and age): _____

Length of Your Present Relationship (if applicable): _____

Children? (Gender and age): _____

Who currently lives in your home with you? _____

PRESENTING PROBLEM(S)

What is/are the main reason(s) for your visit?

_____

_____

_____

_____

MEDICAL (non-psychiatric) HISTORY

Current non-psychiatric medical conditions: _____

_____

Current *non-psychiatric* medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Hospital Admissions/Surgeries: _____

PSYCHIATRIC HISTORY

Have you ever been in therapy before? _____

Previous Therapist's Name	*Dates of Treatment*	*Reason for therapy/counseling?*

Have you ever been hospitalized for psychiatric treatment? _____

Name of Hospital	*Date / Length of Stay*	*Reason for hospitalization?*

Current *Psychiatric* Medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Previous *Psychiatric* Medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Family history of psychiatric illness? _____

Have you ever attempted to harm yourself or kill yourself?_____ If yes, please describe when and how:

Are you *currently* having thoughts about wanting to be dead, harming yourself or killing yourself? _____

SUBSTANCE USE HISTORY

All information is completely confidential

Do you drink alcohol? _____ If yes, how often? _____ How much do you drink when you drink? _____

Do you use recreational drugs? _____

If yes, what kind(s)? _____ How often? _____

_____ How often? _____

Do you use prescription drugs that you don't have a prescription for or prescription drugs that you are using more than prescribed? _____

If yes, what kind(s)? _____ How often? _____

_____ How often? _____

History of alcohol or drug abuse? _____ If yes, please give details: _____

_____

_____

_____

EMPLOYMENT

Present Employment or Student Status: _____

Length of Time: _____ Position/Title: _____

Current Source of income (if not working): _____

MESSAGES FOR DR. WILSON

Is there anything else you want me to know at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Symptom Checklist

Please rate each of the following statements as they apply to you over the past week:

0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = completely true of me

_____	1. I tire quickly.
_____	2. I feel no interest in things.
_____	3. I feel stressed.
_____	4. I want to harm myself.
_____	5. I feel irritated.
_____	6. I feel unhappy in my marriage/significant relationship.
_____	7. I have thoughts of ending my life.
_____	8. I feel weak.
_____	9. I feel fearful.
_____	10. I feel sad.
_____	11. I feel lonely.
_____	12. I feel angry.
_____	13. I feel anxious.
_____	14. I feel worthless.
_____	15. I feel helpless to change things in my life.
_____	16. I feel hopeless about the future.
_____	17. I dislike myself.
_____	18. I have difficulty concentrating
_____	19. I have difficulty remembering things.
_____	20. I have difficulty falling asleep.
_____	21. I have difficulty staying asleep.
_____	22. I awaken early and can't go back to sleep.
_____	23. I have an upset stomach.
_____	24. I have headaches.
_____	25. I have sore muscles.
_____	27. I feel that something bad is going to happen.
_____	28. I have trouble getting along with friends and close acquaintances.
_____	29. My eating habits have changed.
_____	30. I can't shut off my mind.
_____	31. The above symptoms are negatively impacting my ability to function in daily activities.

"Over the past two weeks, my predominant mood has been_____."

"Right now I am feeling_____."

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CONSENT FOR TREATMENT

I have read and understand Dr. John W. Wilson's Office Policies that were provided to me. I know that if I have any questions, I can address them with Dr. John W. Wilson. By signing below, I consent to treatment and authorize Dr. John W. Wilson to provide psychological services for me. I understand that I can discuss diagnosis, treatment options, and progress with Dr. John W. Wilson now or in the future.

_____
Client's Name – Please print

_____ _____
Client or Guardian Signature Date

MANAGED CARE CONSENT TO TREATMENT

(Omit this page if you do not have or plan to use Aetna Insurance)

I,_____, authorize and request that Dr. John W. Wilson, PsyD provide psychological examinations, treatment and/or diagnostic procedures pursuant to the policies of the managed care company, Aetna Behavioral Health or Aetna Student Health (hereafter referred to simply as Aetna) which now or during the course of my care as a patient are advisable. I understand that the frequency and type of treatment will be decided between me, Aetna and Dr. Wilson.

I understand that sometimes managed care companies will only pay for brief treatment which might not be sufficient to meet my needs. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that pursuant to the release of information which I have signed, Dr. Wilson will provide specific information regarding my condition and treatment to Aetna and that Dr. Wilson has no control over how this information might be used.

I understand that I am responsible for payment for any services not paid by Aetna including charges for missed or cancelled appointments. I understand that Aetna may determine not to pay for further services. In such a situation, I understand that I may have to decide whether to continue treatment and take responsibility for my own treatment costs.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Managed Care Consent for Treatment form.

Date:_____ Client Signature: _____

Date:_____ Witness: _____

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Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. I practice within the ethics guidelines of the American and Georgia Psychological Associations and according laws according to the state of Georgia.

PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which follows these Office Policies and is included as part of this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain

your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign the signature page of this form, your signature will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record and that I preserve this record for seven years after your last session. Your paper records are kept in a locked file cabinet in my office and I alone have the key to this cabinet. My office uses *TherapyNotes, Inc*. for records storage, billing, scheduling, and appointment reminders. *TherapyNotes, Inc*. is certified HIPAA- and PCI-compliant, uses fully encrypted databases and has firewalls to protect servers. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $.50 cents per page (and for certain other expenses like postage). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. Pages 1 through 13 of this document are kept in your confidential file in my office. You will keep pages 14 through 19 for your own records.

LIMITS OF CONFIDENTIALITY

The majority of information discussed during the course of therapy with a psychologist is confidential and protected by law. However, there are several important exceptions when confidential information may be released to others without your permission. These exceptions are listed below:

1. There are times when someone's life is in danger. For example, "suicidal and/or homicidal intent" means placing someone in danger (either yourself or someone else) and under those conditions, I am required by law to take necessary action to protect that person. Such action may include hospitalization, notification of the police, notifying an intended victim, etc. PLEASE BE AWARE that I discuss suicidal and homicidal thinking with clients frequently without feeling the need to take action. Such thoughts tend to be more common than most people realize. Discussing the issue alone does not indicate the need for action. Action is taken only when I believe that actual harm may result from such thinking. To protect your life or someone else's is paramount.

2. There are times when I discover, or strongly suspect, that a minor child is being abused, either physically, sexually, or emotionally. State law requires your therapist to report such information to the

Department of Family and Children's Services in the county wherein the child resides. The law is designed to protect children from harm and the obligation to report actual or suspected abuse or neglect is clear.

3. If you are involved in litigation of any kind and inform the court of the services you receive(ed) from us (thereby making your mental health an issue before the court) you may be waiving your right to keep your records confidential. Please consult with your lawyer and your therapist before doing so. By all means, protect yourself from unnecessary intrusions into your privacy.

In Worker's Compensation cases, the law requires disclosure of available records before payment is made. In such cases, I attempt to provide a summary of treatment without specific details. This is not always successful.

4. Should your treatment or psychological testing be "court ordered," you can assume that all the information which you divulge to us will be shared with the court. In such instances, you have a right to tell me only what you want disclosed. However, the withholding of information may harm your case.

5. In many cases, managed care companies require significant disclosure of clinical records so that they can make clinical judgments concerning the need for treatment. The managed care company is responsible for maintaining the utmost confidentiality of your records. However, I cannot guarantee or be responsible for what they may do with the information I provide them. For these reasons, I do not bill third party payers directly. Please see "fees" below for further information.

6. I prefer to coordinate your treatment with your primary physician. With your permission, I may contact and coordinate treatment with your personal physician.

7. Should therapy include your spouse, partner, or other family members, written permission will be required from EACH person before any records will be released.

8. Finally, should you desire that information be communicated about you to someone else, your written permission will be required.

USE OF TECHNOLOGY IN THERAPY

Third Party Vendors

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Electronic Communication Policy

My office cannot ensure the confidentiality of any form of communication through electronic media, including email, text, video conferencing, and fax. Please be advised of the following conditions and limitations:

1. Emailing and texting are not appropriate for urgent or emergency situations. While I make every effort to respond as quickly as possible, I cannot guarantee that any email or text will be read and responded to within any particular period of time.
2. Emails and texts should be concise and limited to appointment scheduling and cancellation. If you need to discuss complex and/or sensitive situations, you should call me, schedule an in-person appointment, or use the *HipaaBridge* app. Unless you are using this secure app, I will not respond via email or text to anything other than logistical and pragmatic issues such as scheduling or canceling an appointment.
3. Emails will usually be printed and filed into your medical record. Texts may be printed and filed as well.
4. I will not forward your identifiable emails and/or texts without the your written consent, except as authorized by law.
5. When and if you choose to use phone calls and/or video conferencing for therapy services or to discuss sensitive material, you are responsible for ensuring that the space from which you are speaking is confidential and that your technology is secure.
6. My office is not liable for any breaches of confidentiality caused by you or any third party.

INTERACTIONS WITH THE LEGAL SYSTEM

I, as your therapist, will not be involved in or engaged in any legal issues or litigation in which you, as my client, are party to at any time either during your counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that you wish to have a copy of your file, and you execute a proper release, I will provide you with a copy of your record, and you will be responsible for charges in producing that record. If you believe it necessary to subpoena me to testify at a deposition or a hearing, you will be responsible for my expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day will be billed at the rate of $375.00 per hour including travel time. Understand that if you subpoena me, I may elect not to speak with your attorney, and a subpoena may result in my withdrawing as your counselor.

FEES AND BILLING

The fee for the initial intake session (60-75 minutes) is $175. The fee for all subsequent sessions (45-50 minutes) is $155, whether individual, couple, or family. Sessions that run over the time allotment are billed on a prorated basis. My fee for additional paperwork (e.g., medical leave certification) is prorated at $155 per hour and is not billable to your insurance company; therefore, you will be expected to pay this fee as it incurs. Fees for expert witness, deposition, and court appearances are outlined in the above section entitled “Interactions With The Legal System.” Fees for reading and returning texts and emails (unless related to scheduling or other logistical concerns) are prorated at $155 per hour.

Payment is expected at the end of each session, unless we agree otherwise prior to that session. Payment can be made by cash or check. Please be aware that if you are attempting to have your services covered through insurance, you are responsible for knowing your deductible and copay prior to the first appointment, and you are responsible for fees that you incur if your insurance company refuses your claim.

CANCELING APPOINTMENTS

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EMERGENCIES AND AFTER HOURS CALLS

In the case of an emergency, please be aware that my office is not staffed 24 hours per day. If you should have a life-threatening emergency, please call 911 or go to your local emergency room. In addition, call my office at **(404) 246-1257** and leave me a message. Please know that I will attempt to return your call as soon as possible. If you call outside of regular work hours or over the weekend, your call may not be returned until the next working day.

Your signature below indicates that you understand and agree to the office policies described herein, that you have been provided a copy of these policies, and that you authorize Dr. John W. Wilson to provide psychotherapy and/or psychological services to you according to these policies. Dr. John W. Wilson's signature below indicates his agreement to also adhere to these policies and to provide treatment based of best standards of care.

_____ _____

Client Signature Date

_____ _____

John W. Wilson, PsyD Date

Please keep the remaining documents for your records:

Office Policies
Notice of Privacy Practices

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_____ _____

Client Signature Date

_____ _____

John W. Wilson, PsyD Date

Dr. John W. Wilson, Psy.D.
Licensed Psychologist

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NOTICE OF PRIVACY PRACTICES (NPP)

This notice will tell you how I handle information about you. It tells how I use this information in this office, how I share it with other professionals and organizations and how you can see it. I want you to know all this so that you can make the best decisions for yourself and your family. I am also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of Georgia are very complicated and I don't want to make you read a lot that may not apply to you, I have simplified some parts. If you have any questions or want to know more about anything in this Notice, please read the complete Notice or ask me for more explanation or more details.

What do I mean by your medical information?

Each time you visit me, or any other health care provider, information is collected about you and your physical and mental health. It may include information about your past or present health or conditions, or treatment you received from me or others, or about payment for health care. This information is known legally as **Protected Health Information**, or PHI. This information goes into your medical or health care record or a file at the office. In this office, PHI is likely to include -

Your history - which may include childhood, school, work, marital and personal information
Reasons you came for treatment - which may include problems, complaints, symptoms, needs, and goals
Diagnoses - diagnoses are the medical or psychological terms for your problems or symptoms.
Treatment Plan - these are the treatments and services that I think would best help you
Progress notes - Each time you come in, I write down how you are doing, what I observe about you and what you tell me
Records I get from others who treated you
Psychological test scores
Legal matters
Billing and insurance information

This list is just to give you an idea – there may be other kinds of information that go into your health care record.

I use this information for many purposes. For example:

- To plan your care and treatment
- To decide how well treatment is working for you
- When talking to other health care professionals who are treating you, such as your family doctor or the professional who referred you to me
- To document that you actually received the services for which you or your insurance company was billed.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about whom, when and why others should have this information.

Although your health care record is the physical property of the doctor who collects the information, the information belongs to you. You can inspect it, read it or review it. If you want a copy, I can make one for you, but there will be a charge for copying and mailing (if you want it to be mailed). In some unusual situations, you cannot see all of
what is in your records. If you find anything in your record that you think is incorrect, or something important is missing you can ask me to amend (add information) although in some rare situations, I do not have to agree to do that.

I will use the information that I get from you mainly to provide you with treatment, to arrange payment, or for some other business activities that are called health care operations. After you read this information, I will ask you to sign a **Consent Form** to let me use and share your information for very specific purposes described in the notice of privacy practices. If you do not consent and sign this form, I cannot treat you.

If you or I want to disclose (send, share, release) your information for any other purposes, I will discuss this with you and ask you to sign an **Authorization** to allow this.

Although I am committed to keeping your health information private, there are times when the law requires me to use or share it. For example,

- When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization able to help prevent or reduce the threat.
- Some lawsuits and legal or court proceedings. If your treatment or evaluation is court ordered, information will be shared with the court and the other parties.
- For Workers Compensation , Social Security Disability Assessment and similar benefit programs

Your Rights Regarding Your Health Information

1. You can ask me to communicate with your health and related issues in specified ways. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. Other than the circumstance outlined in the NPP, I will not discuss your PHI unless I have an authorization. When I have an authorization to disclose information, you have the right to ask me to limit what I tell certain individuals involved in your care. While I do not have to agree to your request, if I do agree, I will keep the agreement except if it is against the law, or in an emergency or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you, such as your medical and billing records. Psychotherapy notes may not be included. You can even have a copy of these records, but there may be a charge. Talk to me to arrange to see your records.

4. If you believe the information in your records is incorrect or incomplete, you can ask me to make some kinds of changes (called amending) to your health care information. You must include the reasons why you want to make the changes. You have to make this request in writing.

5. You have a right to have a copy of this notice. If the policy is changed, a notice will be posted in the waiting room and you can get a copy of these changes.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the US Secretary of the Department of Health and Human Services. All complaints must be filed in writing. If you have any questions regarding this notice or these health information privacy policies, please contact me at (404) 246-1257.

The effective date of this notice is January 21, 2017