Dr. Whitney Calhoun
Psychologist
(404) 491-1893

Midtown Psychotherapy Associates
INNOVATORS IN MENTAL HEALTH

199 Armour Drive Suite E Atlanta, GA 30324
367 Prince Avenue Suite L Athens, GA 30601

New Patient Questionnaire

Name:_____ Date:_____

Address:_____

City: _____ State: _____ Zip:_____

Preferred phone number: _____ Is leaving messages okay? ___Yes ___No

Age: _____ Date of Birth: _____

Referred by: _____

Emergency Contact

Name: _____ Relationship to you:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone number: _____

Occupation

Current job title: _____ Hrs/week: _____

Employer name: _____

Address:_____

City: _____ State: _____ Zip:_____

Education

Highest Level of Education: _____

Last School Attended: _____

Are you currently a student? ____ Yes ____ No

If yes, what school and major? _____

_____

Relationship Status: ___ Single ___ Married ___Divorced ___ Widow/Widower
___ Dating ___ Same-sex partner

(If applicable) How long have you been in your present relationship? _____

Please list who you currently live with and their relationship to you:

_____

_____

_____

Do you have any children? ___ Yes ___No

If yes, please list their names and ages: _____

_____

Have you ever been hospitalized? ___Yes ___No

If yes, please list the date and the reason for hospitalization. Please include hospitalizations due to mental illness, illness, injury or surgery.

_____

_____

_____

_____

Please list any prior treatment you have received for mental health concerns:

Name of Provider	Problems Addressed	Dates of Treatment

Are you currently taking any medications? ___Yes ___No

If yes, please list medication name and dosage.

_____

_____

_____

Are you currently on a diet? ___Yes ___No

If yes, please describe. _____

_____

Have any relatives ever been treated for a mental health condition or substance abuse problems?

If yes, please list their relation to you and condition treated.

_____

_____

Do you have any physical or intellectual disabilities? _____

_____

Please describe what has brought you to therapy.

_____

_____

_____

_____

_____

How have you addressed this in the past?

_____

_____

What do you hope to get out of therapy?

_____

_____

Please describe who else knows what you are struggling with and their relationship to you.

_____

_____

Please list your hobbies and what you like to do for fun.

_____

_____

What coping skills do you have that help you relax or calm down?

_____

_____

Do you currently have any legal involvement? ___Yes ___No

If yes, please describe. This includes divorce, custody, criminal charges, etc.

_____

_____

Please indicate any significant losses you have experienced with a check mark.

___Death of a parent	___Death of a grandparent
___Separation from parent(s)	___Death of other significant family member
___Death of a sibling	___Death of a friend
___Separation from sibling(s)	___Death of a pet
___Death of a spouse/partner	___Divorce
___Separation from children	___Other:

Please indicate your substance use below.

Substance	Yes/No	How often?	How much?	Last use
Alcohol				
Caffeine				
Nicotine				
Marijuana				
Cocaine				
Heroin				

LSD				
Narcotics				
Other:				

Please list the ages at which you first tried alcohol and other substances. _____

_____

_____

As a child, did either of your parents have a problem with alcohol? ___Yes ___No

As a child, did either of your parents take illegal drugs? ___Yes ___No

Did anyone else that lived with you as a child abuse alcohol or other substances? ___Yes ___No

As a child, did an adult ever hit, kick, burn or beat you? ___Yes ___No

As a child, did an adult ever berate, yell at, or overly criticize you? ___Yes ___No

As a child, did anyone ever sexually touch you without your consent? ___Yes ___No

As a child, did anyone ever expose himself or herself to you? ___Yes ___No

As a child, did an adult ever show you pornography? ___Yes ___No

As a child, did anyone ever force you to have sex? ___Yes ___No

As an adult, has a romantic partner ever hit, kicked, burned or beat you? ___Yes ___No

As an adult, has anyone ever sexually touched you without your consent? ___Yes ___No

As an adult, has anyone ever forced or coerced you into having sex? ___Yes ___No

Please indicate with a check mark the areas you would like to work on:

___Anger	___History of verbal or emotional abuse
___Anxiety	___Religious or spiritual concerns
___Depression	___Self-harm
___Domestic violence	___Sexual concerns
___Education/School problems	___Sexual orientation
___Eating difficulties	___Thoughts of harming someone
___Fearfulness	___Thoughts of suicide

___Financial problems	___Trauma
___Health concerns	___Trouble concentrating
___Marital problems	___Trouble sleeping
___Mood swings	___Unhappy most of the time
___Obsessions	___Use of alcohol/drugs
___Pregnancy concerns	___Use of alcohol/drugs by a partner/spouse
___Problems with partner/significant other	___Use of alcohol/drugs by a parent
___Problems with children	___Victim of crime/assault
___Problems with parents	___Vocational goals
___History of physical abuse	___Weight loss/management
___History of sexual abuse	___Other:

Please describe anything else that you would like for me to know about you.

_____

_____

_____

_____

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Informed Consent to Psychotherapy Treatment

Authorization and Consent to Treatment: I am pleased you have chosen me as your provider. Psychotherapy, like any treatment, comes with potential risks and benefits. Potential benefits include symptom reduction, resolving unwanted thoughts, improved relationships with yourself and others, and feeling overall healthier. Potential risks are usually minimal, but because you will be discussing aspects of your life that may be distressing, intense or uncomfortable feelings may arise. Additionally, although psychotherapy is an effective mode of treatment, I cannot guarantee positive results. This is because people respond to psychotherapy differently, and a great deal of the level of success will come from you implementing the things we discuss outside of the therapy office. My commitment to you is to continually work with you and evaluate your progress to determine your best options for treatment. I can assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association (APA), and that I take my role seriously in the sense that I work hard to provide treatment that will be of benefit to you.

Fees: My fee for the initial assessment is $250. My fee for each 45–50-minute psychotherapy session is $200 and the fee for each 75–80-minute session is $300. Any phone calls that last longer than 15 minutes will be charged at a pro-rated amount. A limited number of exceptions to these rates may be made in the case of extenuating circumstances. Fees are payable at the end of each session by credit card, check, or cash. Sessions that are canceled or rescheduled with less than 24 hours notice may be charged at the above rate.

Confidentiality: The law protects the privacy of all communication between a patient and a mental health provider. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements per HIPAA standards. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If you threaten or attempt to commit suicide or otherwise conduct yourself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If you threaten grave bodily harm or death to another person.
3. If I have a reasonable suspicion that you or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If you are being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

8. If you seek insurance reimbursement, I am required to provide a clinical diagnosis. I may be required to provide a copy of the psychological evaluation report. This information will become part of the insurance company files. I have no control over what insurance companies do with this information once it is in their possession. By signing this form, you agree that I can provide requested information to your insurance company.

Emergency Procedures: If you ever need immediate emergency assistance because you are at imminent risk of harming yourself or others, you should first call 911 or go to the nearest hospital. If you have an emergency in which your immediate safety is not threatened and you need to reach me, you can call me at (478) 227-0766. If you do not reach me, leave a message and I will return emergency calls as quickly as I can. If you call in the evening or during the weekend, I may not receive your message until the next business day. I encourage you to also use alternative forms of assistance if needed, such as 1) calling a friend or other member of your support network or 2) utilizing the National Suicide Prevention Hotline at (800) 273-8255.

Supervision: I am currently obtaining my licensure in the state of Georgia to be an independent clinical psychologist. I work under the supervision of Dr. Amy Smith-Barnes, a licensed psychologist at Midtown Psychotherapy Associates. She provides weekly supervision where I update her on the progress of all of my cases. Thus, she will be aware of who I am seeing and the progress of psychotherapy. If you have questions or concerns for Dr. Smith-Barnes, you may reach her at (404) 983-1337.

Special Circumstances: I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution and do not specialize in services or evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. If you anticipate that this is needed, I will refer you to professionals who have this area of specialization in their practice. Although very unlikely, it is important that I share the following information in advance: In the event that I am required by subpoena or court order to testify in any matter related to the psychological evaluation or psychotherapeutic services, you will be expected to pay for all of the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are $ 350 per hour for preparation and attendance at any legal proceeding.

I, the undersigned, have read and understand the above information (Informed Consent) and I consent to treatment under these conditions. I understand I have the right to withdraw consent at any time. I further acknowledge that Dr. Whitney Calhoun has provided me with the Notice of Policies and Practices to Protect the Privacy of Your Health Information.

_____
Client Name

_____ _____
Client Signature Date of Signature

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FINANCIAL AGREEMENT / CREDIT CARD AUTHORIZATION FORM

Fees: Clients seen by Dr. Whitney Calhoun, PhD agree to pay $250 for the initial assessment. Therapy sessions are $200 per 45-50 minute session or $300 per 75-80 minute session. Any services beyond these standard sessions, such as phone consultation exceeding 15 minutes or excessive paperwork for reports or insurance company requests will incur additional fees at a pro-rated amount, to be discussed prior to service provided. Whitney Calhoun, PhD reserves the right to announce fee changes, which upon effective date shall become current for all existing clients. Cash, checks and credit cards will be accepted as forms of payment. Checks are made payable to Virginia Highland Psychology, LLC. You will be provided a "superbill" at the time of service serving as record and receipt for all charges. This should be used to submit for reimbursement from your insurance company. You are responsible for contacting your insurance company regarding the rate of reimbursement, if any, prior to entering this contract for services. Please note that there is a $25 fee for returned checks. Should you miss a payment, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

All clients are required to provide a credit card number to keep on file in the case of missed appointments or late cancellations. This information is kept on our confidential EHR (Theranest), which is in accordance with HIPAA guidelines. If you "no show" or cancel your appointment without 24-hour or more notice, the equivalent of one session fee may be charged to your card. Please note that insurance companies do not reimburse for missed appointments.

I hereby authorize Dr. Whitney Calhoun (dba Virginia Highland Psychology LLC) to charge my credit card as follows:

Card type: MC Visa Discover AMEX HSA

Name on Card: _____

Credit Card Number: _____

Exp. Date: _____

CV code: _____

Address with Card: _____

_____

I have read, understand and agree to the above fee payment and credit card policy for service provided by Dr. Whitney Calhoun(dba Virginia Highland Psychology LLC).

_____ _____

Client Signature Date

Dr. Whitney Calhoun
Psychologist
(404) 491-1893

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367 Prince Avenue Suite L Athens, GA 30601

NOTICE OF 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.

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 healthcare provider, such as your family physician or another psychologist/social worker.
    - 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 practice group, such as sharing, employing, applying,

utilizing, examining, and analyzing information that identifies you.

- "Disclosure" applies to activities outside of my practice group, 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, and 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 and health care operations, I will obtain an authorization via a Release of Information 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, and the 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 reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or I observe a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, I must notify Child Protective Services.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to Adult Protective Services as soon as I become aware of the situation. A "vulnerable adult" means an elder adult, or an adult who has a mental or physical impairment which substantially affects his or her ability to: (a) provide personal protection; (b)provide necessities such as food, shelter, clothing, or mental or other health care; (c) obtain services necessary for health, safety, or welfare; (d) carry out the activities of daily living; (e) manage his or her own resources; or (f) comprehend the nature and consequences of remaining in a situation of abuse, neglect, abandonment or exploitation.
- **Health Oversight:** If you file a complaint against me with the Utah Division of Occupational and Professional Licensing, I may disclose to them information from your records relevant to the complaint.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, including yourself, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records which are essential to protect the rights and safety of others and yourself. I also have such a duty if you have a history of physical violence of which I am aware and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

IV. Patient's Rights and Provider'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 about you. 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. Upon 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.

Initials _____

• **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 regarding you. 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.
• **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You** have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
• **Right to be Notified if There is a Breach of Your Unsecured PHI:** You have a right to be notified if: 1) use or disclosure of your PHI in violation of the HIPAA Privacy Rule, b) the PHI has not been encrypted to government standards, and c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Provider'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 a copy of the revised policies and procedures at our next scheduled 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 me so that we can discuss your concerns. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the following address:

Midtown Psychotherapy Associates
199 Armour Drive NE, Suite E
Atlanta, Ga. 30324
404-685-1600, Fax: 678-666-1149

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, or the Georgia Board of Psychological Examiners. 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 the date undersigned by you. 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. If you are an active patient when I make a change, I will provide you with a revised notice upon your request. I will post my current privacy policy on my website.

Initials _____

I have read and reviewed this policy. I understand and agree to its contents. A copy of this document was provided to me.

_____
Client Name

_____ _____
Client Signature Date of Signature

Initials _____

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COVID-19 Informed Consent & Waiver for In-Office Services

This document contains important information about your consent to gradually resume in-office services during the COVID-19 pandemic. Please read this carefully. When you sign this document, it will constitute a contract between you and Midtown Psychotherapy Associates and affiliated clinicians, (hereinafter referred to "The Practice"). The Practice team cares about you and wants you to make an informed decision with your informed consent concerning the return to in office services. Please do not hesitate to call our office for additional information, or any concerns.

Your Responsibility and Commitment to Minimize COVID-19 Exposure

To obtain/resume in office services, you will need to sign this document and agree to take certain precautions to help keep The Practice staff, our families, and other patients safer from exposure to COVID-19, illness and possible death. By signing this document, you agree to follow all of The Practice safety policies and the health guidelines posted by The Centers for Disease Control and Prevention (CDC) to help maintain the safety of everyone who is working and those seeking services from The Practice. **Please refer to our "Policies for Resuming In-Office Services" for more details.**

If you do not adhere to The Practice "Policies for Resuming In-Office Services," we will not meet in person. You will have to call to reschedule and may be assessed a late cancelation fee. If clients generally do not comply with the policies, this will result in The Practice scheduling only telehealth appointments. **The Practice retains the right to deny appointments to anyone not complying with the guidelines** and maintains the right to return to telehealth arrangements for clients who we deem to be symptomatic, or otherwise a safety risk, in our sole discretion. The Practice may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will notify you about any necessary changes.

Maintaining Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, The Practice may be required to notify local health authorities that you have been in the office. If you have tested positive and you have been in our office in the recent past, The Practice will also need to inform other clients and staff who you may have crossed paths with you so they know they have had exposure. However, please know that if The Practice has to report this to local health authorities, The Practice will only

provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. If The Practice informs other clients or staff that an in-office client tested positive, we will not disclose your identity or any identifying information to anyone other than your treating therapist if you have not already done so. By signing this form, you agree that The Practice may do so without an additional signed release.

Please Read Carefully

1. I understand that The Practice is **NOT** responsible for the risk associated with returning to in-office services and cannot be sued for any possible exposure to COVID-19. If I contract COVID-19 while seeking in-office services, I will not sue The Practice. As such, and in consideration of the services provided by The Practice, I individually and on behalf of my child(ren), hereby release, covenant not to sue, discharge, and hold harmless The Practice its officers, employees, agents, and representatives of and from any and all claims, including all liabilities, actions, damages, costs or expenses of any kind arising out of or relating to in office services or coronavirus exposure. I understand and agree that this release includes any claims based on the acts, omissions, or negligence of The Practice, its officers, employees, agents, and representatives, whether a coronavirus infection occurs before, during, or after participation in any in-person appointments.

2. I acknowledge and agree that if I have symptoms or have tested positive for coronavirus, I will inform The Practice, and I agree to seek treatment via telehealth and **will NOT return to in office services until a medical doctor or nurse has given me written authority to do so**. **The Practice** retains the right to cancel any appointment for any Client showing symptoms.

3. I understand and acknowledge that, by coming to the physical office, **I am responsible** for the risk of exposure to COVID-19 (or other public health risks). I understand that this risk may increase if I have a job that directly/indirectly exposes me to COVID-19 or I travel using public transportation, cab, or ridesharing services, e.g., Uber, Lyft.

4. I understand that by signing this document, I agree to follow **ALL** posted safety policies found in the **"Polices for Resuming In-Office Services"** information sheet, and I will follow guidelines posted by the CDC while seeking in-office services.

I acknowledge and agree to these terms and conditions.

_____ _____

Patient/Client Date