# Child/Adolescent Information Sheet

**Provider: William A. MacGillivray, Ph.D.**

**Today's Date:_____**

Child's Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Sex:_____ Age:_____

Birthdate:_____ Social Security Number:_____

Highest Grade Completed:_____ Current School:_____

Mother's Name:_____

Address/City/Zip:_____

Home Phone:(____)_____Work Phone:(___)_____

Cellular Phone:(____)_____ Pager:(____)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Father's Name:_____

Address/City/Zip:_____

Home Phone(_____)_____ Work Phone:(_____)_____

Cellular Phone:(____)_____ Pager:(____)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Who should be contacted in case of emergency?_____

Phone:(____)_____ Relationship to child:_____

Are the child's parents separated or divorced? YES NO If YES, when?_____

Who has legal custody of this child? Mother Father Other

List the child's brothers/sisters and/or stepsiblings:

Name Age Living with Child? Problems

_____

_____

_____

_____

Who referred you?_____ Phone:(____)_____

May I contact him/her to acknowledge the referral? YES NO

Briefly describe your reason for seeking help now:_____

_____

How long has this been a problem ?_____

Primary Care Physician:_____ Phone:(____)_____

Does the child have any legal problems? YES NO (If YES, please explain)_____

_____

Do you want this office to file insurance claims for you? YES NO
If "YES," complete this section. If "NO," skip this section.

Have you called your insurance company to pre-authorize these services? YES NO

Primary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Secondary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Who is responsible for the bill?_____

Will you be paying today by: Check_____ Cash_____

***THANK YOU*** for completing this questionnaire. ***PLEASE*** let me know if any of the information changes.

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## ***CONSENT TO EVALUATE/ASSESS/TREAT A MINOR***

Patient:_____

Address:_____

Date of Birth:_____

I hereby authorize William A. MacGillivray, Ph.D. to evaluate, assess, and/or treat my child/ward, _____.

Signature:_____ Date:_____
Parent or Legal Guardian

Witness:_____ Date:_____

**William A. MacGillivray, Ph.D.**
**679B Emory Valley Road**
**Oak Ridge, TN 37830**
**Voice Mail: (865) 216-2685**

## AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize William A. MacGillivray, Ph.D. to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named therapist. I also authorize above-named therapist to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau or court of law, if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my Insurance Company and/or insurance plan management company to pay William A. MacGillivray, Ph.D. such amount as may be payable pursuant to the provision of my contract.

Date:_____ Patient or Guardian's Signature:_____

## PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by William A. MacGillivray, Ph.D. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named therapist in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

**A copy of this form is as valid as the original.**

William A. MacGillivray, Ph.D.
Clinical Psychologist

679B Emory Valley Road
Oak Ridge, TN 37830
Voice Mail (865) 212-2685

## CONFIDENTIALITY

According to Tennessee law, all communications between the therapist and the client, including the knowledge that the professional relationship exists, are confidential. The client controls this information regarding service. There are three exceptions to this rule; all exceptions involve the therapist's duty to try to preserve safety when people are in danger. The therapist may breach the requirement of confidentiality when, in the case of emergency, there is imminent danger to the client or an imminent danger to another person, or there is suspected child abuse. Tennessee Law requires that any suspected child abuse be reported to the Tennessee Department of Human Services for investigation.

Please be advised: ***Confidentiality cannot be guaranteed in situations involving insurance reimbursement or managed care when you give consent for clinical information to be given to a third party for precertification or payment purposes***. After clinical information is received by the third party, the use and confidentiality of the information are beyond the control of this office.

## BENEFITS AND CONSEQUENCES OF PSYCHOTHERAPY

People entering psychotherapy should realize that they might make significant changes in their lives. Through counseling, clients may begin to feel differently about themselves. Clients often modify their emotions, behaviors, and/or attitudes. They may change employment, make changes in their relationships, or make changes in other significant aspects of their lives. If you have any questions about the benefits and consequences of psychotherapy, please feel free to ask me.

## EXPECTATIONS

I will be glad to discuss any questions you may have about services, fees, or the therapy process. You are free and encouraged at any time to discuss my qualifications, experience and educational background as it pertains to this professional relationship. You are welcome to discuss concerns you might have with this document, and you are encouraged to read it over and to discuss it at this or later appointments.

## FEES

The fee for the initial evaluation is ***$150.00***. Regular psychotherapy lasting 45-50 minutes will be ***$120.00*** per session. The fee for psychological testing or neurofeedback is $120 per hour.

APPOINTMENTS

Appointments are 45-50 minutes in length, unless otherwise discussed and agreed upon. Regular appointment times will be scheduled, and this time will be reserved for you. Please be prompt in keeping your appointments. Changes in time need to be discussed in advance. If you are unable to keep your appointment, please give at least 24 hours notice; otherwise, you (not your insurance company) will be charged a fee for the time reserved. Exceptional conditions will be considered.

AVAILABILITY

If your call is urgent, or you want to be sure I receive it quickly after hours or on weekends, please call (865) 212-2685, leave message and then press 14 so that your call will be marked as urgent.

EMERGENCIES

In case of emergency and I am unavailable, you can go to the nearest emergency room where you will have access to qualified health professionals.

CANCELLATIONS

If you need to cancel an appointment please let me know within 24-hours of your appointment time. Otherwise a fee will be charged to you, not your insurance company, for the missed appointment.

METHOD OF PAYMENT

Some insurance companies will pay, in part, for psychotherapy services. While you are ultimately responsible for all charges (including collection and/or legal costs if the account becomes delinquent), I can assist you in getting reimbursement from your insurance company. Where appropriate, your deductible and/or co-payment are due at the time of service.

Please sign and date below:

I have read, understand, and agree to these policies. I give my consent for evaluation and treatment by William A. MacGillivray, Ph.D. I have been given a copy of this form and a copy of the "Patient Bill of Rights."

Signature_____ Date:_____

# Patient's Bill of Rights

## Patient's rights include:

- The right to be treated with dignity and respect.
- The right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- The right to have their treatment and other member information kept private. Only in an emergency, or if required by law, can records be released without member permission.
- The right to information from staff/providers in a language they can understand.
- The right to have an easy to understand explanation of their condition and treatment.
- The right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.
- The right to get information about the managed care company's services and role in the treatment process.
- The right to information about providers.
- The right to know the clinical guidelines used in providing and/or managing their care.
- The right to provide input on the managed care company's policy and services.
- The right to know about the complaint, grievance and appeal process.
- The right to know about State and Federal laws that relates to their rights and responsibilities.
- The right to know of their rights and responsibilities in the treatment process.
- The right to share in the formation of their plan of care.

## Patients have a responsibility to:

- Give providers information they need. This is so they can deliver the best possible care.
- Let their provider know when the treatment plan no longer works for them.
- Follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Treat those giving them care with dignity and respect.
- Not take actions that could harm the lives of the managed care company's employees, providers, provider's employees or other patients.
- Keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- Ask their provider questions about their care. This is so they can understand their care and their role in that care.
- Let their provider know about problems with paying fees.
- Follow the plans and instructions for their care. The care is to be agreed upon by the member and the provider.

Patient Signature: _____

Date: _____