

# Ψ COASTAL PSYCHOLOGY

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Walter B. Branch, Ph.D.  
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322 Stephenson Ave., Suite B  
Savannah, Georgia 31405  
Telephone: (912) 352-2992  
Fax: (912) 352-3447  
www.CoastalPsychology.com  
CoastalPsych@aol.com

Dear \_\_\_\_\_

We are looking forward to seeing you (your son; your daughter) for your (his; her) initial visit on \_\_\_\_\_  
\_\_\_\_\_. This letter is to help make your visit as comfortable as possible and to  
inform you of our office policies and procedures.

**FOR YOUR FIRST APPOINTMENT, PLEASE ARRIVE TEN MINUTES EARLY SO THAT YOUR CHART CAN BE MADE. PLEASE HAVE THE ENCLOSED PAPERWORK COMPLETED WHEN YOU ARRIVE AND BRING YOUR INSURANCE CARD WITH YOU. THE DOCTORS KEEP A TIGHT SCHEDULE AND WILL USUALLY START YOUR APPOINTMENT ON TIME.**

1. Office hours may vary but are usually Monday - Friday, 8:00 - 6:00.
2. Confidentiality between psychologist and patient is guaranteed by Georgia law except under extenuating circumstances (for example, if the patient is suicidal; we are also required to report suspected child abuse and homicidal threats or intentions). Your written consent must be on file before any records can be released to another individual or agency. You will also be required to sign a HIPPA notice.
3. When you make an appointment, please understand that this time is reserved for you. You will usually be seen on time though delays are sometimes unavoidable. If you are late, that cuts into your appointment time. If you must cancel an appointment, **please give 24 hours notice. When we are not notified, there is a \$75.00 charge for missed appointments.**
4. The fee for a diagnostic interview is \$150.00. The fee for psychotherapy (45 minute session) is \$125.00. Psychological testing and evaluation are billed according to the amount of time spent in the administration, scoring, and interpretation of tests and in the preparation of a report.
5. We will do our best to work with you regarding payment for services. If your deductible is not satisfied, please be prepared to pay for the initial visit. You may pay by check, cash, Mastercard, Visa, or American Express. Your cost share (that portion not covered by insurance) is due at the time services are rendered.
6. Insurance companies and policies vary in their coverage of mental health services. Many of you have benefits managed by a Managed Care Organization. Please check your insurance card and call the 800 number to check on your benefits and have your initial visit pre-certified.
7. In consulting your insurance policy handbook or your insurance/managed care company, be sure that psychological services (provided by a Licensed Psychologist) are covered. You may also want to address the following questions.
  - Is psychological testing covered? What tests (e.g., intellectual and academic) are NOT covered?
  - Are certain diagnoses not covered?
  - Do you require a referral from your primary care physician?
  - What percentage of the charges are covered for outpatient services?
  - Have you satisfied your deductible? What is your co-payment?
8. Please understand that we cannot guarantee or be responsible for your insurance coverage. Full payment of charges for professional services is your responsibility. In the event your account is left unpaid and we find it necessary to turn your account over to an outside collection agency, **a fee equaling 25% of the balance owed will be added.**

If you have any questions, please do not hesitate to ask -- we will be happy to answer them.

Thank you.

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Vickey Barnwell  
Insurance Manager

Debbie James  
Receptionist

Amanda Kendrick  
Office Assistant

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**FINANCIAL RESPONSIBILITY**

Coastal Psychology will file your insurance claim (when requested) and make all reasonable efforts to collect reimbursement from the insurance company. However, this does not release the patient, guarantor, or responsible party from financial responsibility. If, for some reason, claims are not paid by the insurance company, then it is your responsibility to pay for professional services. In all cases, payment of the deductible and co-insurance portion of the bill should be made at the time of service.

**THEREFORE**

I understand that I am responsible for payment for services rendered by Coastal Psychology.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE AND ASSIGNMENT**

I authorize the release of necessary information to process my insurance claims.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**MISSED APPOINTMENTS**

I understand that I will be billed for any appointment which is not canceled more than 24 hours in advance. I also understand that third party payers (insurance companies) will not be billed for missed appointments. **Payment must be made prior to the next scheduled appointment. If an appointment for testing is missed, the testing will not be routinely rescheduled.**

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I consent, agree, and authorize evaluation and treatment by Coastal Psychology. I have read and signed the Patient's Rights and Responsibilities as well as the HIPPA notice.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

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## Intake/Adult

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*Please initial that it is ok to call to confirm your appointment: home \_\_\_\_\_ work \_\_\_\_\_  
cell \_\_\_\_\_ e-mail \_\_\_\_\_*

### Spouse (if married)

Spouse's Name: \_\_\_\_\_

Spouse's Place of Employment: \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_

**Guarantor Information** (just write *same* if the patient is the guarantor)

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information**

***Primary Insurance***

Name of Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

***Secondary Insurance***

Name of Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact**

*Should we need to get a message to you, please initial that it is ok to contact this person:* \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Family: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Any special instructions you may need to tell us:**

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The following directions should assist you in finding Coastal Psychology.

If you are traveling east on Interstate 16: Take the third exit past I-95. This will be the Lynes Parkway (South/East). Follow this road for about 7 miles and it will turn into a 6 lane divided highway (DeRenne Avenue). Make a right turn at the third red light -- this is Abercorn Street. Continue on Abercorn Street past the Twelve Oaks Center (on your left) and through various red lights including Lee Blvd. and Jackson Blvd. You will make a left at the next light which is Stephenson Ave. Go to the second light (Hodgson Memorial Drive) and make a left turn into our parking lot. We are in the beige stucco building next to Georgia Pediatrics. Our address is 322 Stephenson Avenue.

If you are coming over the Talmadge Bridge from South Carolina, stay on I-16 for several miles. Take the **second** Lynes Parkway exit (heading South/East toward Savannah). Follow this road for about 7 miles and it will turn into a 6 lane divided highway (DeRenne Avenue). Make a right turn at the third red light -- this is Abercorn Street. Continue on Abercorn Street past the Twelve Oaks Center (on your left) and through various red lights including Lee Blvd. and Jackson Blvd. You will make a left at the next light which is Stephenson Ave. Go to the second light (Hodgson Memorial Drive) and make a left turn into our parking lot. We are in the beige stucco building next to Georgia Pediatrics. Our address is 322 Stephenson Avenue.

If you are traveling into town on 204 (Abercorn Extension): Go past the Savannah Mall (on your left) and after about four miles you will come to the Oglethorpe Mall (on your right). Continue past Mall Blvd. and then Eisenhower Drive. The next light is Stephenson Ave. Turn right onto Stephenson. Go to the second light (Hodgson Memorial Drive) and make a left turn into our parking lot. We are in the beige stucco building next to Georgia Pediatrics. Our address is 322 Stephenson Avenue. If you are coming from Waters Avenue, turn onto Stephenson at the CVS store and go to the next light (Hodgson Memorial Drive). Turn right into our parking lot.

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## A Notice to All of Our Patients

We are here to serve you and help you to the best of our ability. We try to schedule appointments so that the office runs smoothly and you have very little wait for your session. Please remember the sessions are scheduled for 45 minutes, not an hour. Help us stay on time by respecting the time limits of your appointment.

While we strive to stay on time and respect your time demands, we are disturbed by an increasing number of late cancellations and missed appointments. As our office policy states (in the initial paperwork you filled out), there is a charge for missed visits and late cancellations (failure to give 24 hours notice). We do our best to fill cancellations and you will not be charged if we are successful in filling the appointment.

If there is a missed visit charge, it must be paid prior to or at the time of your next visit. If you “no show” two appointments in a row (without giving us notification), we will assume our services are no longer necessary and cancel any remaining appointments that you may have scheduled.

When yourself (or your child) is scheduled for testing, time slots from 1.5 up to 4 hours are blocked out for you. We cannot easily fill that time when we get a last minute cancellation and we obviously cannot fill the time when we do not know that you are not coming. Please understand, therefore, that last minute cancellations or no shows (other than emergencies and situations beyond your control) will not be tolerated; you will be charged for a missed visit and we do not guarantee that the testing will be rescheduled.

Please remember that we can not file a missed visit with your insurance company and that this policy applies to **all** patients.

Worker’s Compensation patients: missed visits will be billed to your attorney and paid at the time your case settles. By signing this agreement, you are giving us (and your attorney) permission for this financial arrangement.

We trust you will understand our policy regarding missed appointments and late cancellations. Please sign below indicating you understand our office policy.

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Name of Guarantor

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Date

We are required by Federal Law to give you  
this form to read and sign. Thank you for  
your assistance in this matter.

## 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 health care. 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 activities, 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 of 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 health care operations, I will obtain an authorization 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, 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 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.

### **IV. 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 provide you with the revision at your next 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 your treating psychologist, Victoria Barnwell (office manager) or Dr. Nagelberg (Practice Manager) at 912/352-2992.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Dr. Nagelberg at 322 Stephenson Avenue, Savannah, GA 31405 or via e-mail [MVinSAV@aol.com](mailto:MVinSAV@aol.com).

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with 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 on May 16, 2003.

I have read the Georgia Notice Form provided by Coastal Psychology.

\_\_\_\_\_

Name

Date

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## \*PATIENT'S RIGHTS AND RESPONSIBILITIES

### Statement of Patient's Rights

- Every patient will be treated with dignity and respect.
- Every patient will be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Every patient will be assured that all patient information is kept confidential (except in extenuating circumstances).
- Every patient will be afforded all of his/her rights and privileges guaranteed by State and Federal laws.
- Every patient has the right to know the name, professional status, and function of those behavioral health care practitioners involved in his/her care and treatment.
- Every patient will be provided with a complete, easily understood explanation of his/her condition and treatment.
- Every patient will receive assistance with respect to knowing and understanding his/her benefits.
- Every patient will be involved in decisions involving his/her treatment.
- Every patient will be informed of the consequences of refusing treatment and/or not complying with prescribed treatment.
- Every patient will be informed of scientific research and has the right to agree or refuse to participate in this research.
- Every patient will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- Every patient will be afforded every reasonable effort to accommodate his/her cultural, language, or gender preferences in the selection of a provider.
- Every patient will be provided with sufficient information to enable him/her to render informed consent to treatment except in emergencies.

### Statement of Patient's Responsibilities

- Every patient is encouraged to treat the provider with dignity and respect.
- Every patient is encouraged to provide accurate information.
- Every patient is encouraged to comply with the provider recommendations for treatment and to discuss concerns with the provider and/or the managed care organization.
- Every patient is expected to avoid actions or threats that endanger the lives or health of providers, employees, or other patients.
- Every patient is expected not to engage in illegal acts, such as forging or falsifying a provider's name on documents requiring a provider's signature.
- Every patient is required to pay any fees at the time of the appointment.
- Every patient is requested to keep scheduled appointments or to notify to provider as soon as possible regarding a missed appointment. There is a charge for missed appointments when not canceled 24 hours in advance.
- Every patient is requested to notify the provider if he/she decides to discontinue treatment.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

The signature below shows that I have explained this statement to the patient and have offered a copy of this form to the patient.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\*Adapted from Magellan Behavioral Health