

**MICHAEL S. McGARRY, Ph.D., P.C.**  
4015 SOUTH COBB DRIVE, SUITE 1  
SMYRNA, GA 30080-6303  
770-435-5453 • FAX 770-435-9357

**CLIENT INFORMATION** (The client is the person who was authorized for treatment)

CLIENT NAME \_\_\_\_\_ MARITAL STATUS S  M  D  W   
MALE  FEMALE  SSN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ AGE \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME # \_\_\_\_\_  
WORK # \_\_\_\_\_ Ext. \_\_\_\_\_ OTHER # \_\_\_\_\_ Pgr.  Cell   
EMPLOYER OR SCHOOL \_\_\_\_\_ POSITION OR GRADE LEVEL \_\_\_\_\_

**PRIMARY INSURANCE** (The insured is the primary card holder)

PRIMARY CARD HOLDER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MALE  FEMALE  SSN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ RELATIONSHIP TO CLIENT \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME # \_\_\_\_\_  
WORK # \_\_\_\_\_ Ext. \_\_\_\_\_ OTHER # \_\_\_\_\_ Pgr.  Cell   
EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_ MANAGED CARE COMPANY \_\_\_\_\_  
BENEFIT AND CLAIMS PHONE # \_\_\_\_\_ PRE AUTHORIZATIONS PHONE # \_\_\_\_\_  
ID# \_\_\_\_\_ POLICY/GROUP # \_\_\_\_\_ PLAN # \_\_\_\_\_

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ HOME # \_\_\_\_\_  
WORK # \_\_\_\_\_ Ext. \_\_\_\_\_ OTHER # \_\_\_\_\_ Pgr.  Cell

**FOR OFFICE USE ONLY** Date Verified \_\_\_\_\_ CS Rep. \_\_\_\_\_

Eff. Term. \_\_\_\_\_ PC/PA no yes \_\_\_\_\_

Yearly Max. \_\_\_\_\_ \$ V Ded. \$ \_\_\_\_\_ Ins. Pays \_\_\_\_\_ \$ %

Lifetime Max. \_\_\_\_\_ \$ V Bal. \$ \_\_\_\_\_ Pt. Pays \_\_\_\_\_ \$ %

Claims Address \_\_\_\_\_

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Client Name \_\_\_\_\_

Insured ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_

## GUARANTY OF PAYMENT

Initial \_\_\_\_\_ In consideration of psychological services extended to the undersigned insured (or dependent), I/We guarantee payment in full to Michael S. McGarry, Ph.D. for the amount due for these psychological services. In the event this account is collected by law or through an attorney at law, the undersigned agrees to pay all reasonable costs of collection. I/We understand that the debt incurred cannot be removed by the declaration of bankruptcy.

## AUTHORIZATION TO RELEASE INFORMATION

Initial \_\_\_\_\_ I/We authorize Michael S. McGarry, Ph.D., P.C. to file with my insurance carrier(s) for any benefits due under that policy for these services and authorize the release to that insurance carrier any information required for the completion of that claim.  
I/We authorize Michael S. McGarry, Ph.D., P.C. to coordinate my treatment with the managed care company that authorizes the services provided and to provide them with the information they require to determine my eligibility for these services.

## ASSIGNMENT OF BENEFITS

Initial \_\_\_\_\_ I assign to Michael S. McGarry, Ph.D., P.C. any benefits due me by any third party carrier for services rendered to the undersigned insured (or dependent), and do authorize and instruct such third parties to make payment of any benefits directly to Michael S. McGarry, Ph.D., P.C. I understand that the check for any benefits due and a copy of applicable benefits summary form will be mailed directly to Michael S. McGarry, Ph.D., P.C. I further agree that this assignment shall not be revoked without the consent of Dr. McGarry.

## MISSED APPOINTMENTS

Initial \_\_\_\_\_ I understand that I will be charged a penalty fee equivalent to Dr. McGarry's full session rate for an appointment not kept or not canceled or changed with at least a 24 hour notice. I also understand that this charge is not reimbursable by a third party payor.

## POLICIES, SERVICES AGREEMENT AND GEORGIA NOTICE FORM

Initial \_\_\_\_\_ I have been given, have read, and agree to follow the office policies, procedures, services agreement, and the HIPAA Georgia Notice Form regarding Protected Health Information.

## STATEMENT OF UNDERSTANDING

Initial \_\_\_\_\_ I give my consent to treatment voluntarily. If I am the parent or legal custodian of a minor child under age 18 and that person is to be the client in therapy, I give my consent to treat that person, and attest that I am the custodial parent/legal guardian of that person. I further agree to relinquish access to my child's records, and to receive only general information about progress and session attendance.

\_\_\_\_\_  
Client signature or legal custodian if client is a minor

\_\_\_\_\_  
Date

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Client Name \_\_\_\_\_  
Insured ID # \_\_\_\_\_  
Date of Birth \_\_\_\_\_

## PHYSICIAN AND MEDICATIONS

PHYSICIAN NAME \_\_\_\_\_ OFFICE # \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

MEDICATIONS \_\_\_\_\_ DOSAGE \_\_\_\_\_

\_\_\_\_\_ DOSAGE \_\_\_\_\_

\_\_\_\_\_ DOSAGE \_\_\_\_\_

INITIAL ONE: \_\_\_\_\_ I authorize Dr. McGarry to exchange any applicable information with the above named physician.

\_\_\_\_\_ I **DO NOT** authorize Dr. McGarry to release any applicable information to the above named physician.

\_\_\_\_\_  
Client signature or legal custodian if client is a minor

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

Dear Dr. \_\_\_\_\_:

The above named patient was recently see at my office on \_\_\_\_\_.

I hope the following information will be helpful in coordinating care.

Treatment Plan: Individual Therapy \_\_\_\_\_ x per month Family Therapy \_\_\_\_\_ x per month

Diagnosis: Axis I \_\_\_\_\_ Axis II \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I will follow this client until the end of this episode.

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Client Name \_\_\_\_\_

Insured ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_

## COORDINATION OF BENEFITS

Please complete the appropriate shaded area if any of the following apply:

1. The client **is also** the insured (primary cardholder) for **more than one** policy regardless of whether or not both policies cover mental health and/or substance abuse benefits.

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SSN \_\_\_\_\_ INSURED'S EMPLOYER \_\_\_\_\_  
SECONDARY HEALTH PLAN NAME \_\_\_\_\_ POLICY # \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_ SINGLE COVERAGE \_\_\_\_\_ FAMILY COVERAGE \_\_\_\_\_  
IF FAMILY COVERAGE, LIST ALL COVERED MEMBERS \_\_\_\_\_

2. The client and the insured (primary cardholder) **are not** the same person.  
(i.e., the client is the spouse or a dependent of the primary cardholder)

PRIMARY CARDHOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SSN \_\_\_\_\_ PRIMARY CARDHOLDER'S EMPLOYER \_\_\_\_\_  
IS CLIENT EMPLOYED YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, CLIENT'S EMPLOYER \_\_\_\_\_  
IS CLIENT COVERED UNDER HIS/HER EMPLOYER'S HEALTH PLAN? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, EMPLOYER'S HEALTH PLAN NAME \_\_\_\_\_ POLICY # \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_ SINGLE COVERAGE \_\_\_\_\_ FAMILY COVERAGE \_\_\_\_\_  
IF FAMILY COVERAGE, LIST ALL COVERED MEMBERS \_\_\_\_\_

3. The client is a minor **and** the parents are divorced.

NAME OF LEGAL CUSTODIAN \_\_\_\_\_ RELATIONSHIP TO CLIENT \_\_\_\_\_  
PERSON RESPONSIBLE FOR DEPENDANT HEALTHCARE PER DIVORCE DECREE \_\_\_\_\_  
IS DEPENDANT COVERED UNDER MORE THAN ONE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, NAME OF PRIMARY CARDHOLDER FOR SECONDARY INSURANCE \_\_\_\_\_  
PRIMARY CARDHOLDER'S DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_  
HEALTH PLAN NAME \_\_\_\_\_ POLICY # \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_ SINGLE COVERAGE \_\_\_\_\_ FAMILY COVERAGE \_\_\_\_\_  
IF FAMILY COVERAGE, LIST ALL COVERED MEMBERS \_\_\_\_\_

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand a copy of this authorization shall be valid as the original.

Signature

Relationship to Primary Card Holder

Date

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Client Name \_\_\_\_\_

Insured ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize Michael S. McGarry, Ph.D.  
Please print client name

to disclose to     to obtain from     to exchange with

\_\_\_\_\_  
Name of agency, attorney, school counselor, therapist, etc.

\_\_\_\_\_  
Address, city, state and zip code

\_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

the following information:

for the following purpose:

This authorization may be withdrawn at any time in writing except to the extent that Michael S. McGarry, Ph.D. has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires ninety (90) days following completion or termination of treatment, except for information to be released or exchanged for purposes of a claim for benefits. If for a claim for benefits, this release of information expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Client signature or legal custodian if client is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

To The Recipient of Confidential Information:

If the information disclosed to you relates to substance abuse treatment, these records' confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.

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**MICHAEL S. McGARRY, Ph.D., P.C.**  
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www.atlantatherapist.com

## **OFFICE POLICIES, PROCEDURES AND SERVICES AGREEMENT**

### *WELCOME...AND WHAT TO EXPECT*

Welcome to my practice! I am looking forward to our sessions together. My approach is active and supportive, using strengths and working as a team. I use solution-focused therapy, emphasizing specific goals and expecting positive change.

In your first session of therapy, we will create a written treatment plan together. This plan will be based on questions I ask you about your history, information you tell me about the problems which made you decide to come for therapy, and the results of some basic screening questionnaires you fill out.

From all of this data, we will agree on goals for therapy, a general time frame for achieving these goals, and the steps for moving from where you currently are to where you want to be psychologically.

Throughout the sessions we have, I will give you homework assignments to complete between sessions. Homework will often include reading, writing, and practicing things we've talked about during the session. It is very important to your progress that you complete the homework between sessions.

At each session we will evaluate how you feel you are doing toward reaching your goals, and we may modify your treatment plan if necessary. When we feel you have accomplished what you wanted, we'll stop our sessions, with the understanding that if you need to come back for additional work in other areas in the future that you may call to schedule.

### *WHAT IS A PSYCHOLOGIST?*

A psychologist is a specialist in evaluating, diagnosing, and treating emotional and behavioral problems. Psychologists have a doctoral degree and typically spend about seven years in graduate study after completing their undergraduate degree in college.

A psychologist with a Ph.D. also writes a lengthy scholarly research paper called a dissertation in an area of special interest and must present an oral report on that research in front of a panel of faculty members from the university.

A practical pre-doctoral (before the degree) and post-doctoral internship with supervision from experienced clinicians must be completed before a psychologist can practice independently.

Psychologists are licensed in the state where they practice and must pass a standardized written test and oral examination by the board of psychologists after completing their degree and internship in order to be licensed.

Psychologists are subject to a strict code of professional ethics, must complete continuing education classes and are accountable for demonstration of ongoing clinical competence.

### *PSYCHOLOGICAL SERVICES*

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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. But there are no guarantees of what you will experience.

#### *PSYCHOLOGIST-CLIENT SERVICES AGREEMENT*

This section contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new 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 the intake 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.

#### *LIMITS ON CONFIDENTIALITY*

The law protects the privacy of all communications between a patient and a psychologist. 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 imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members and contractors have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my written permission.
- I have contracts with accountants, an answering service, computer technicians and consultants, and a transcriptionist. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

**There are some situations where I am permitted or required to disclose information without either your consent or Authorization:**

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children's Services or the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- 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 to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

## ***PROFESSIONAL RECORDS***

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. 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 reasonably 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.

## ***PATIENT RIGHTS***

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

## ***MINORS AND PARENTS***

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

## ***BILLING AND PAYMENTS***

In return for my spending 45 minutes in a therapy session with you, you will be expected to pay for this service. If you have insurance, the insurance company may pay for part of this fee. We will be happy to file your insurance for you, but **you are responsible for assuring that the insurance company pays their part of your bill.** I am paid different rates by different insurance companies. If you have questions about any charges or fees, please feel free to discuss these with me or my office manager. **The parts of my fee not covered by insurance (the copay and/or coinsurance and deductible) are your responsibility, and I will expect you to pay them at the time of the session.** You are required to know how much your part of the fee will be, and to be sure that your sessions are authorized ahead of time by the insurance company or the managed care company administering the benefits for the insurance company. This is usually done by calling the number for **mental health services** on your insurance card. My office manager may be able to assist you in this process if you have questions or problems. Please remember that when a managed care company authorizes sessions, the paperwork contains a disclaimer that says that **even though they are authorizing the service, they cannot guarantee payment. This is the responsibility of you and your insurance company.**

Your therapy appointment time is reserved only for you. This is different from some other doctor's offices, where more than one person may be scheduled at the same time. If you run late to an appointment, it will still end at the scheduled time, because someone has a scheduled appointment right after yours. **IF YOU MISS AN APPOINTMENT FOR ANY REASON, YOU WILL BE CHARGED A PENALTY FEE IF YOU DO NOT CALL AT LEAST 24 HOURS IN ADVANCE OF YOUR APPOINTMENT TO CANCEL THE APPOINTMENT. THIS FEE IS THE SAME FEE THAT YOUR INSURANCE COMPANY WOULD HAVE PAID ME IF YOU HAD COME TO THE SESSION PLUS YOUR COPAYMENT. YOUR INSURANCE WILL NOT PAY THIS FEE. IF YOU NEED TO CANCEL AN APPOINTMENT, CALL THE OFFICE AND SPEAK WITH THE OFFICE MANAGER, OR LEAVE A VOICE MAIL WITH MY ANSWERING SERVICE AT ANY TIME 24 HOURS A DAY. E-MAIL OR WRITTEN CANCELLATION NOTICES WILL NOT BE ACCEPTED.** I have highlighted this information because it is the part of therapy that my clients most frequently don't understand. To avoid conflict between us or getting upset later, please remember this part especially.

If you have an emergency between sessions and need me to call you to address concerns that cannot wait until the next session, I will charge you for this time at my regular rates. Please be aware that your insurance will not pay for this time.

If you ask me to write a letter for you to anyone about your therapy, there will be a charge for this service. This fee is also not covered by insurance. The fee may vary depending upon the time I must spend writing the letter.

If you direct me to speak with anyone about your therapy, this time will be charged to you at my regular rates. Again, insurance will not pay for this service. This category includes time spent with attorneys, teachers, or other professionals on your behalf. It also includes travel time if I must leave my office. The only exception to these charges is when your primary care doctor or a psychiatrist is prescribing medication associated with your treatment.

I accept cash, checks, and money orders as payment for your therapy. **Credit cards are not accepted.** In the event that you have a check returned to me for non-payment of funds, you will be expected to pay for the associated costs I have. These charges will include a returned check charge and any bank charges I incur. I may also ask you to pay by cash or money order in the future.

## ***EMERGENCY AND AFTER HOURS CALLS***

I schedule appointments and am in my office from 7:30 a.m. to 8:30 p.m., on an alternating workweek schedule. This schedule is Monday through Thursday one week and Tuesday through Friday on the other. My office manager typically is in the office from approximately 7:30 a.m. until 5:30 p.m. on the days I am in the office. During these hours, the phone will usually be answered by my office manager. If the office manager does not answer, you will be able to leave a message on the voice mail system if all lines are busy or if the office manager has temporarily left the office. You can expect your call to be returned, normally within one hour, if you leave a message under these circumstances.

If you call when the office is closed or on the weekend, your call will be returned the day the office reopens if it is a routine matter like scheduling or re-scheduling an appointment or asking questions about your bill or insurance payments. **IF YOU HAVE AN EMERGENCY**, you will hear recorded instructions about how to contact me, or the on-call therapist if I am out of town or on vacation. Follow these instructions and you should hear from me or the on-call therapist within a few minutes. If for any reason you do not get a return call, there may have been a problem with either how you followed the instructions or with my communication system. If after trying a second time there is no return call, contact the emergency room of the hospital covered by your insurance company or call **911**.

Revised 03/01/07

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## **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 practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my practice 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.

You may revoke any authorization 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 post the revisions on my website at [www.atlantatherapist.com](http://www.atlantatherapist.com). A written copy will be provided upon written request.

#### 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 at my office telephone number, which is 770-435-5453.

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 me at my office address, which is 4015 South Cobb Drive SE, Suite #1, Smyrna, GA 30080.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I 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 is effective April 14, 2003.

I reserve the right to change the terms of this notice, make restrictions or limitations, and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting the revisions on my website at [www.atlantatherapist.com](http://www.atlantatherapist.com). A written copy will be provided upon written request.