# Walter B. Branch, Ph.D.

## Savannah Psychological Specialists, LLC

www.SavannahPsych.com
email: savannahpsych@gmail.com

1980 Chatham Parkway, Suite 701
Savannah, Georgia 31405
Telephone: (912) 777-5761
Fax: (912) 777-5762

We are looking forward to seeing your son or daughter. These forms will help make your visit as comfortable as possible and inform you of our office policies and procedures.

PLEASE READ AND COMPLETE THESE FORMS IN THEIR ENTIRETY.
PLEASE ARRIVE TO YOUR APPOINTMENT ON TIME!

Dr. Branch will usually see you at your appointment time. There is usually very little wait time, or no wait time, before seeing Dr. Branch. If you arrive late, your appointment time may be shortened. If you must cancel an appointment, please give us enough time to fill the appointment from our waiting list. Please bring your insurance card with you.

1. Office hours are Monday - Thursday 8:15-2:00; 4:00 - 5:45. The office is closed on Friday, Saturday and Sunday. There is usually not an office manager available. If you call, please leave a message.

2. Confidentiality between psychologist and patient is guaranteed by Georgia law except under certain circumstances. For example, psychologists are required to report suspected child abuse and homicidal threats or intentions. Please read and sign the enclosed HIPPA notice.

3. The fee for your first visit, called a Diagnostic Interview, is $150.00. Psychological testing and evaluation are separate fees and are billed according to the amount of time spent in the administration, scoring, and interpretation of tests and in the preparation of a report.

4. 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.

5. Mental Health is usually treated differently from physical health by insurance companies. Insurance policies vary in their coverage of mental health services. Many people have benefits managed by a Managed Care Organization, which is not the insurance company. IT IS STRONGLY RECOMMENDED that you call your insurance company before your first visit to ask questions about your mental health benefits. Questions you might want to ask include: Are visits to Dr. Branch covered? Is Dr. Branch a provider with my insurance. Is psychological testing and/or therapy covered? Are certain diagnoses not covered? Do I need a referral from my primary care physician? Have I met my deductible? What is my co-payment?

6. Please understand that we cannot guarantee or be responsible for your insurance coverage. Insurance coverage varies depending upon your employer. 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.

7. In cases of divorce we expect payment from the parent signing these forms and who brings the child to the appointment, regardless of what your divorce decree may say. Unless ordered so by a judge, Dr. Branch treats both parents in cases of divorce as if both have legal guardianship. Dr. Branch does not keep “secrets” nor does he hide information. Dr. Branch DOE NOT do custody work, nor does he make recommendations for visitation. He is on no one’s “side.”

8. If a child is referred to Dr. Branch from a physician or other health care professional, it is understood that Dr. Branch may send a copy of the report and/or notes to the health care professional.

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### Patient Demographic Information

Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

School: _____ Grade: _____

### Parent Information

Mother's Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Father's Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Insurance Information

*Primary Insurance*

Name of Insurance Company:_____

Policy #: _____ Group #: _____

Name of Insured: _____ ID or SS#: _____

*Secondary Insurance*

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Name of Insured: _____ ID or SS#: _____

Emergency Contact

Please indicate an emergency contact person.
Name: _____Relationship to Child: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____

We sometimes, but not always, make a courtesy reminder call the day before your visit(s). Regardless of whether a courtesy call is made, you are still responsible for keeping any visits you have scheduled.

Any special instructions you may need to tell us?

If you have any questions about these forms, please call.

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## Patient Clinical Information

Child's Name: _____ Age: _____ Date of Birth: _____
Who referred you to us? _____
With whom does this child live : _____
Ages and sex of siblings: _____

School Problems:

Name of School: _____ Grade:_____
What kind of grades does this child usually make? _____
What behavior problem in school, if any, does this child have? _____
_____
Has the teacher noted any problems with attention span or overactivity? If yes, please explain
_____
_____
Has this child been retained? If so, which grade(s) _____
Has this child been tested by the school psychologist? _____
Is this child in special education? _____

Home Problems (please exlain problems in any of these areas):
How is your child's attention span:

Homework problems:

Behavior problems:

Describe any problems with hyperactivity:

Any problems in public places:

Aggression:

Temper Tantrums:

Discipline problems:

Hours sleeping per night:

Bad dreams or bed wetting:

How is your child's appetite?

Does your child seem happy?

Any crying spells:

Any history of physical or sexual abuse:

Any suicidal thoughts or behaviors :

Any social skills problems?

Any sensitivities to sounds, clothing or textures of food:

What are you child's interests and activities:

Developmental History:

Did mom have any problems with her pregnancy or delivery? _____
_____
Birthplace _____ Birthweight _____ Any colic _____
Age of first words: _____ Age of first steps: _____
What was this child like as a toddler and preschooler? _____
_____
_____

Any history of neurological problems?_____
Any history of speech or language therapy? _____
Any hearing or vision problems? _____
Any prior psychological testing? _____
_____
_____
Any prior psychological treatment or counseling? _____
_____

Is there a family history of psychological problems? _____
_____
Are there any substance abuse problems? _____
Any involvement with the police or Juvenile Court? _____
_____
Who is this child's pediatrician? _____
Are there any medical problems? _____
Is this child taking any medications (if yes, which ones)?_____
_____

Any other comments?

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### FINANCIAL RESPONSIBILITY

Savannah Psychological Specialists will file your insurance claim and make all reasonable efforts to collect reimbursement from your insurance company. However, this does not release the parent, 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 copay ,deductible and/or co-insurance portion of the bill should be made at the time of service. We accept Visa, Mastercard, American Express, Discover, and checks. In cases of divorce we expect payment from the parent signing these forms and who brings the child to the appointment, regardless of what your divorce decree may say.

### THEREFORE

I understand that I am responsible for payment for services rendered by Savannah Psychological Specialists.

_____ _____
Signature of Parent or Responsible Party Date:

### RELEASE AND ASSIGNMENT

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

_____ _____
Signature of Parent or Responsible Party Date

### MISSED APPOINTMENTS

I understand that I will be billed for any appointment which is not canceled in time to fill it from the waiting list. I also understand that insurance companies can not be billed for missed appointments. The fee is $20.00. Payment for a missed visit must be made before any future appointments are scheduled.

_____ _____
Signature of Parent or Responsible Party Date

### CONSENT

I consent, agree, and authorize evaluation and/or treatment by Savannah Psychological Specialists. I have read and signed the Patient's Rights and Responsibilities as well as the HIPPA notice.

_____ _____
Signature of Parent or Responsible Party Date

### MEDICAID ONLY

I understand that if Medicaid has any other insurance on record, and I actually do not have that insurance, Medicaid will not pay Dr. Branch for services he performs and I will be completely responsible for the bill. I also understand that if my child's Medicaid is not active on the date of service, then I will be completely responsible for paying the bill.

_____ _____
Signature of Parent or Responsible Party Date

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## Finding Savannah Psychological Specialists

Our office is located at the geographic center of Chatham county and is easily accessible from the city of Savannah and surrounding communities. Parking is plentiful and hassle free.

From Downtown Savannah - Take I-16. Exit onto Chatham Parkway. Turn right and go over I-16. Go through the intersection at Hwy 17 (McDonald's is on the right). Turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back, left side - Suite 701.

From Midtown Savannah - Take DeRenne toward 516. Exit right onto Veterans Parkway. Exit onto Chatham Parkway then take an immediate right at the Seed Church. (Redgate will be on the left). There are three buildings in front of the church. Our office is the back building, left side - Suite 701.

From Southside Savannah/Georgetown/Ellabell (and Beaufort, SC) - Drive down GA 204/Abercorn. Get onto Veteran's Parkway (the "flyover" near the Forest River bridge). Exit right at Chatham Parkway entrance ramp. Turn left onto Chatham Parkway. Drive only a few feet, then take the first right at the Seed Church. (Redgate will be on the left). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Richmond Hill - Drive down Hwy-17 until it intersects Chatham Parkway. Turn right onto Chatham Parkway (McDonald's is on the left). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building , left side - Suite 701.

From Pooler and Bloomingdale - Drive down I-16 or Hwy 80 until it intersects Chatham Parkway. Exit right onto Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Port Wentworth - Drive down 516 to Veterans Parkway. Take Veterans Parkway exit to Chatham Parkway. Turn right onto Chatham Parkway, then take an immediate right at the Seed Church (Redgate will be on the left). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From the North end, drive down I-95 until it intersects I-16. Take I-16 to Chatham Parkway. Exit right onto Chatham Parkway. Drive down Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From Garden City - Drive down Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three buildings in front of the church. Our office is in the back building, left side - Suite 701.

From South Carolina (Hilton Head) - Drive over the Talmadge Bridge and stay on I-16. Exit onto Chatham Parkway. Keep right. Continue on Chatham Parkway. Go through the intersection at I-17 (McDonald's is on the right). Go over the viaduct and turn left at the Seed Church (Redgate will be on the right). There are three building in front of the church. Our office is in the back building, left side - Suite 701.

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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 at 912/777-5761.

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. Walter B. Branch, 1980 Chatham Parkway, Suite 701, Savannah, GA 31405 or via e-mail savanahpsych@gmail.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 January 1, 2014.

I have read the Georgia Notice Form provided by Savannah Psychological Specialists.

_____ _____

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 fights and privilges guarenteed 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 process should a dispute arise over treatment and/or claims.

Every patient will be afforded every reasonable effort to accommodate is/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 the provider as soon as possible regarding a missed appointment. There is a charge for missed appointments when not canceled in time to fill the appointment.

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.

_____

Parent Signature Date

The signature below shows that I have offered a copy of this form to the paent

_____

Provider Signature Date