Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Welcome!

This questionnaire is to assist me in better understanding your situation/problem. I recognize that there are a lot of questions, so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. I will review this questionnaire and discuss it thoroughly together with you in our first appointment.

Treatment with my office is voluntary and can be terminated at any time without penalty. My goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have any questions, concerns or ways I might improve my services, I would appreciate your input.

I understand that, in all cases, strict standards of confidentiality and professional ethics will be maintained. I strive to protect and preserve the confidentiality of the patient's personal health information. I have a detailed document called the "Notice of Privacy Practices." It contains more information about policies and practices protecting the patient's privacy and is available upon request. I understand that I have the right to read the "Notice" before signing.

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood the Notice of Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

I authorize Stephanie Lacy, LCSW LMFT, LLC to release and / or obtain my records to/from other physicians for the purpose of continuity of care.

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

AUTHORIZATION FOR TREATMENT & PAYMENT

I hereby consent to treatment by the health care provider Stephanie Lacy, LCSW LMFT,LLC

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

Print Full Name

404-345-7062
770-234-5448 (FAX)

LACY THERAPY
Clinical Social Worker • Marriage & Family Therapist

311 GREEN STREET
SUITE 408
GAINESVILLE, GEORGIA 30501

Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Financial Policy and Assignment of Benefits

It is the policy of my office to request payment for services at the time the service is rendered. If it would be more helpful for you to pay the deductible and co-pay, I will be glad as a service to file your insurance for you. However, I cannot guarantee payment in part or in full by any insurance company or other third party, and therefore, you are ultimately responsible for any charges you incur. Co-payments are requested at the time of service. Your insurance requires that we collect a co-pay according to my contract with them. I accept payments by credit card, debit card, cash or check. However, there is a 3% service charge for debit/credit cards payments. If you incur a balance and it is not paid within 30 days from the date of service, a $25.00 billing fee will be added to your balance.

Missed Appointments and Cancellations

I require a 24-hour notice of cancellation if you are unable to keep your scheduled appointment. There will be a charge of $75.00 for any appointment which is not cancelled with a 24-hour notice. For art journaling missed appointments that were confirmed on the prior Friday, there will be a charge of $15.00. Please be aware that your insurance company will not reimburse for missed appointments.

Insurance Information

Insured's Name: _____ Insured's Date of Birth: _____
Insured's Phone No.:_____ Insured's SS#: _____
Insured's Address: _____
City: _____ State: _____ Zip: _____

Primary Insurance

Insurance Co.: _____ Policy #: _____

Employer: _____ Group #: _____

Secondary Insurance

Insurance Co.: _____ Policy #: _____

Employer: _____ Group #: _____

Note: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying the office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parents insurance carrier will be accepted only after this office has his/her signature on file.

I HAVE READ AND UNDERSTOOD THE ABOVE BILLING POLICY, I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE.

Assignment of Benefits: I authorize the release of any information necessary to process claims and direct payment to myself or the provider who accepts assignment.

_____

Signature of Client, Parent or Guardian Relationship to Client Date

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