

Anne E. Heath, PhD

LICENSED PSYCHOLOGIST

2531 NW 41ST STREET, Gainesville, FL 32606

(352) 448-0880

New Patient Information Sheet

Today's Date: _____ D.O.B. _____ Age: _____

Name: _____ Soc. Sec. # _____

Address: _____
Street City & State
Zip Code _____

Home Ph. # _____ Business Ph. # _____ Cell Ph. # _____

Email address: _____

Marital Status: _____ How Long? _____

Children (include age and sex) _____

Employer: _____ How Long? _____

Occupation: _____

Whom may we thank for referring you to our office? _____

Briefly explain what problems bring you here _____

Is your problem the result of an accident or illness? _____

If so, what is the date of occurrence? _____

ANNE E. HEATH, Ph.D.
2531 NW 41ST STREET, Gainesville, FL 32606
(352) 256-3385

The following information has to do with the policies of my practice. If you have any questions or concerns, please feel free to bring them to my attention.

PAYMENT

Payments for services are on a fee for service basis, payable by cash, check or credit card. Several insurances are accepted, including Blue Cross & Blue Shield and Medicare. I will submit the insurance for you.

The fee charged is for a 50 minute session (for couples and family therapy, 80 minutes), with the exception of the first meeting, which is one hour. The fee for the first meeting is therefore slightly higher, given increased time and paperwork. I ask that you pay for the session at the time of each visit. If this is not possible, please discuss this with me, so that we can arrange an alternative plan. My standard fee for a 50 minute appointment is \$180. I offer a **\$40 discount** for time-of-service cash payment (not credit or debit card).

CANCELLATIONS

If you need to cancel a session, please give at least 24 hours notice; otherwise, I will need to bill you half the charge (NOT your usual co-payment), but half of the full charge for the session. The same applies to missed sessions. MISSED, NON-CANCELLED SESSIONS CANNOT BE BILLED TO YOUR INSURANCE.

INSURANCE

If you expect to receive reimbursement from your insurance, you should be aware of the conditions of your particular policy (such as the amount of coverage per year, restrictions on services or providers, whether there is a co-payment expected, the amount of your deductible, pre-existing conditions, etc.). If you expect to receive payment from Florida Blue Cross/Blue Shield, I can bill them directly for you; if there is a co-payment required, I ask that you pay that amount at each visit. If you will be reimbursed by any other insurance company or third party, you are responsible for submitting the necessary forms, and I will help complete any items which need my signature

OTHER CHARGES

I do not routinely charge for phone calls with clients, school personnel, physicians, etc. unless: 1) the call is considered a phone session, or 2) the call extends beyond 15 minutes. If it is an extended call, it will be billed for the amount of time at my customary hourly rate.

CONFIDENTIALITY

Service provided to you, as well as the records maintained in my files, are confidential. I will only release information if you request it with a signed consent of release for information. The limits of confidentiality are legally determined. If I believe that you may harm yourself or harm another person, I am required to protect you or the person who has been threatened. If such a situation arises, I will attempt to discuss the matter with you prior to taking action, unless there is a good reason not to. If I believe or suspect that a child, an elderly person, or disabled person is being abused by neglect, assault, battery, or sexual molestation, a report must be filed with the appropriate state agency, by you or me. The agency will determine whether or not to investigate the situation.

If you use health insurance to pay part of my fees, I have to give the insurance company some information about our therapy. This usually is only your diagnosis, fee, meeting dates and sometimes a treatment plan or summary of treatment. It is usually against the law for insurers to release any data about our office visits without your written permission. While I believe that the insurance company will act ethically and legally, I cannot control who sees this information at the insurer's office.

In the case of accounts which have outstanding balances, and about which there has been no effort to communicate or establish payment plans, I have the right to turn the account over to a collections agency after two months time. I will provide the collection agency only the information they require in order to collect on the account. You are responsible for additional fees and charges involved once a collection agency is utilized.

MISCELLANEOUS

You will be advised of any fee increases at least three months before an increase occurs; if there is a problem, I would be happy to discuss it with you. You will also be informed ahead of time of any days I will be away from the office; if I am away on vacation, I will arrange for coverage, and will leave the name and number of the covering therapist on my answering machine. In the event that the covering therapist will need to get involved, I will release only such information that is pertinent. I may at times discuss clinical situations with colleagues; when I do so, I will keep all names and identifying information confidential.

Please sign, acknowledging that you have read this letter.

Name _____ Date _____