WELCOME!

The information below should answer most of the questions that you will have before your first appointment –

1. My office is located at 200 Glen Eagles Court, Suite 9B in Carrollton, Georgia (it's at Glen Eagles Professional Office Park that is near both the Carrollton City Schools and the intersection of Hayes Mills Road and the Hwy 166 Bypass). As you come into the main entrance, my office is in the middle building (Bldg. 200). The first two doors from the left side of the building are marked "A" and "B" above them; my office is at the end of hallway "B". Please make sure that you have looked at the detailed directions to my office on my website if you have not already done this (at drmcbee.com under "location").

2. If you have an in-person appointment, there is a waiting area immediately to your left when you enter doorway "B" (although there is also a sitting area on the "A" hallway that is connected by a short cross hallway that you may also use if there are not empty chairs available on the "B" hallway). If you have a telehealth appointment, please refer to that information in the packet.

3. I use a 3rd party billing company, so you will likely be contacted by one of their representatives before your first visit to explain the details about your health insurance policy (including what you will owe on your first visit). If you have questions about your bill in the future, you may discuss those with me and/or a representative from my billing company and we will do our best to help you make sense of it all.

4. Please bring all the new patient documents in the packet filled out at the time of your first appointment (this way, we will not need to take any time away from your appointment for paperwork).

5. For new psychotherapy patients, your first visit will be about 1 hour long; for most patients, subsequent visits will be around 45-60 minutes (depending on your needs and what is required by your insurance company). For patients scheduled for a pre-surgical assessment or other psychological evaluation, the time needed will be around 2.5 hours on the day of the evaluation. Please Note: Because the waiting area for the building is relatively small and is not comfortable for extended periods, it is best to leave family members and friends at home whenever possible. If you need to bring someone with you, they will likely be more comfortable sitting in the car reading or taking that time to grab a bite to eat.

If you have questions that cannot wait until the time of your appointment, feel free to call my office (if am not able to answer your call, please leave a message and I will return your call as soon as I am able). I look forward to seeing you very soon!

Dr. Norlydia Fulbright McBee
Clinical Psychologist

Norlydia F. McBee, Ph.D.
Clinical Psychologist
Georgia License 002727

200 Glen Eagles Court, Suite 9B, Carrollton, GA 30117 Office: (770) 834-0995 Fax: (770) 834-0935 DrMcBee@DrMcBee.com

Patient Information

NAME OF PATIENT _____ DATE _____

DOB: _____ NAME OF PARENT IF A MINOR _____

MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ MOBILE PHONE _____ WORK PHONE _____
EMAIL ADDRESS _____

MARITAL STATUS _____ NAME OF SPOUSE/PARTNER _____
RACE _____ YEARS OF EDUCATION _____ OCCUPATION _____

FAMILY PHYSICIAN _____ PHONE _____
ADDRESS _____ ZIP _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
RELATIONSHIP TO YOU _____ PHONE 1 _____ PHONE 2 _____
ADDRESS _____ ZIP _____

INSURANCE COMPANY _____ NAME OF INSURED _____
INSURANCE ID _____ GROUP NUMBER _____
WHO IS FINANCIALLY RESPONSIBLE? _____ PHONE _____

WHO REFERRED YOU TO ME? _____ MAY I THANK HIM/HER FOR THE REFERRAL? ☐ YES ☐ NO

I authorize and request that my insurance company pay directly to Dr. McBee, or her representative, the amount due on my claim for outpatient psychotherapy or other psychological services. Any deductibles and/or co-payments are my responsibility. I understand that Dr. McBee uses a billing service whose employees will be provided with information about me necessary to file an insurance claim and obtain payment for her services and I authorize Dr. McBee to provide the billing service the necessary information to file claims and obtain payments for the services she provides to me. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered regardless of my insurance status. I have read and completed the information on this form and I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in this information. In consideration of Dr. McBee's agreement to perform this service for me, I hereby release Dr. McBee and each of the parties with whom Dr. McBee exchanges and/or releases information with my permission, from all liability, legal, professional, financial, or otherwise, that might directly or indirectly result from the release or exchange of any information that might be relevant to this consultation or evaluation. I fully understand, agree, and take sole responsibility that the information released may be detrimental and damaging to me personally, to me financially, and to me legally. I understand and agree that this is a legally binding document, that I have had the opportunity to consult with an attorney on this matter if I desire, that I fully understand the rights and privileges that I now waive by signing this agreement that I give this release, authorization, and consent of my own free will. I agree that a photocopy of this form and my signature below is as valid as the original.

Patient Signature _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____

NORLYDIA F. MCBEE, PH.D.
LICENSED PSYCHOLOGIST
200 GLEN EAGLES COURT, SUITE 9B, CARROLLTON, GEORGIA 30117 . OFFICE (770) 834-0995 / FAX (770) 834-0935

TESTING CONSENT FORM

Welcome to my practice. This form will provide information about my services and about your rights and responsibilities as a client. Please be sure to discuss any you have with me. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

TESTING:

This Psychological Evaluation is being conducted at the request of _____ and is therefore somewhat different than other psychological services. While the results of this evaluation may or may not be helpful to you personally, the goal of this evaluation is to provide information to the agency requesting the evaluation about how you are functioning psychologically.

Using a variety of standard psychological tests, I will attempt to answer the questions that have brought you to my practice for this assessment. These questions generally concern disabilities; academic functioning; readiness for surgery, school, or work; and/or personality functioning. This service does not constitute a treating psychologist-patient relationship. In this capacity, my opinions are independent and impartial. Throughout the assessment process, you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretation, and recommendations.

The evaluation itself consists of separate parts, such as oral interview and psychological testing. In addition, it may be necessary for me to review other related materials such as court records, medical records, previous psychological records, etc., and consult with other professionals involved in this matter. If at any time you have a question about any aspect of the evaluation or these procedures, please feel free to ask me. In addition, if at any time you desire a break from the evaluation, please let me know and we will stop. Once testing is completed, the data will be analyzed and a report will be written and sent to the agency or individual who has requested this evaluation.

CONFIDENTIALITY:

Because the evaluation was requested by another party, the confidentiality may have fewer legal protections. I will not release the information unless I am instructed to do so by the person or entity that hired me, or if I am legally required to do so. There are other rare situations in which I am required by law to release information with or without your permission. These are: 1) if there is evidence of physical and/or sexual abuse of children, the elderly, or other individuals unable to protect themselves (such as individuals who are mentally retarded; 2) if I believe you are in danger of harming yourself or another individual; and 3) if your records are subpoenaed by the court. In these rare situations, I would attempt to discuss my intentions with you before an action is taken, and I would limit disclosure of confidential information to the minimum necessary to insure safety. Your participation in this evaluation is voluntary. I will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at any time.

AGREEMENT:

I have read the above material, and I fully understand my rights and obligations as a client of Dr. Norlydia McBee. I freely agree to this assessment.

_____
Name of Client

_____ _____
Signature Date
(Client or parent/legal guardian)

_____ _____
Clinician's Signature Date

NORLYDIA F. MCBEE, PH.D.
LICENSED PSYCHOLOGIST
200 GLEN EAGLES COURT, SUITE 9B CARROLLTON, GEORGIA 30117 . OFFICE (770) 834-0995 / FAX (770) 834-0935

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE Dr. Norlydia McBee, her agents, representatives, employees, and/or business associates to use, release, or disclose the protected health information described below to:

_____
(name of your insurance company)

Information to be disclosed (*check one*):
X_ All medical and psychological information about me, including medical and psychosocial history (that may include information about sexual abuse, sexual assault, abortion, or other sensitive issues); testing and test results; diagnoses, prognosis and treatment of any mental condition, including: Any disorder of the immune systems, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes; Any communicable disease or disorder; Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnoses, functional status, the treatment plan, symptoms, prognosis and progress to date; and Any condition, treatment or therapy related to substance abuse, including alcohol and drugs.

___ Other (*specify*): _____

This authorization will expire (*check one only*):
___ One (1) year from the signature date below, or
___ On (*date*) _____, or
X_ On occurrence of the following event: Dr. McBee receives full payment for professional services rendered to me.

Purpose of disclosure:
__ To disclose the information at my request
X_Other purpose (specify): To obtain payment for services from my insurance company.

Special Instructions or limitations: _None_____
(if none, please write "none")

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of HIPPA policies for Dr. McBee and have been provided an opportunity to discuss any concerns that I may have about the use or misuse of my health information with her. I understand that Dr. McBee, her agents, representatives, employees, and other business associates assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dr. McBee, her agents, representatives, employees, and other business associates from all legal liability that may arise from this authorization. The person whose medical/psychological records are hereby authorized for release or that person's representative may revoke this authorization by notifying Dr. McBee in writing. Federal law requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient. I acknowledge that I have read the authorization. I agree that a photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon my request.

Printed Name: _____ Date of Birth: _____
Mailing Address:
_____

Signature: _____ Date Authorization Signed: _____

My relationship to the patient (if signed by a guardian/parent) is: _____

NORLYDIA F. MCBEE, PH.D.
LICENSED PSYCHOLOGIST
200 GLEN EAGLES COURT, SUITE 9B, CARROLLTON, GEORGIA 30117 . OFFICE (770) 834-0995 / FAX (770) 834-0935

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE Dr. Norlydia McBee, her agents, representatives, employees, and/or business associates to use, release, or disclose the protected health information described below to:

_____
(Name and address of person/organization to whom information should be sent) This may be the requesting health care provider.

Information to be disclosed (*check one*):

X All medical and psychological information about me, including medical and psychosocial history (that may include information about sexual abuse, sexual assault, abortion, or other sensitive issues); testing and test results; diagnoses, prognosis and treatment of any mental condition, including:

- Any disorder of the immune systems, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes; Any communicable disease or disorder; Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnoses, functional status, the treatment plan, symptoms, prognosis and progress to date; and Any condition, treatment or therapy related to substance abuse, including alcohol and drugs.

___ Other (*specify*): _____

This authorization will expire (*check one only*):

X One (1) year from the signature date below, or

___ On (*date*) _____, or

___ On occurrence of the following event: _____

Purpose of disclosure:

X To disclose the information at my request

___ Other purpose (specify): _____

Special Instructions or limitations: None
(if none, please write "none")

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of Dr. McBee's policies and procedures for HIPPA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns that I may have about the use or misuse of my health information with Dr. McBee. I understand that Dr. McBee, her agents, representatives, employees, and other business associates assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dr. McBee, her agents, representatives, employees, and other business associates from all legal liability that may arise from this authorization. I acknowledge that I have read the authorization. I agree that a photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon my request.

Name (please print): _____ Date of Birth: _____

Address: _____ Telephone: _____

Signed: _____ Date this Authorization Executed: _____

If the signature above is not that of the person whose medical/psychological records are being authorized to be released, I am acting for the person whose medical/psychological records are being authorized for release:

My relationship to such person is: _____ Signed: _____

The person whose medical/psychological records are hereby authorized for release or that person's representative may revoke this authorization by notifying Dr. McBee in writing. Federal law states that treatment, payment, enrollment, and eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

Norlydia F. McBee, Ph.D.
Licensed Psychologist
200 Glen Eagles Court, Suite 9B, Carrollton, Georgia 30117
Phone 770.834.0995 Fax 770.834.0935

Payment Agreement for Psychological Assessments

I understand that I am responsible for all reasonable and customary fees that my insurance company does not pay such as deductibles, co-insurance, co-pays, and charges not covered by my insurance. I also understand that to assist me in receiving payment from my insurance company for covered charges Dr. McBee and/or her representative have attempted to obtain an estimate of the cost of her services to me and that Dr. McBee and/or her representative relied on information obtained from my insurance company and/or determined through other means of calculation in order to provide any estimate. I understand that Dr. McBee will be billing my insurance company for those psychological services that are covered by insurance. However, I understand that even an authorization by an insurance company is not a guarantee of payment by that insurance company and that insurance companies sometimes deny payment for a claim for a variety of reasons that are often out of the direct control of the provider. I also understand that any balance that is billed to me as a result of a copay, co-insurance, remaining deductible, or no-show/late cancellation fee, or other service that is not covered by my insurance company is fully my responsibility. Therefore, I agree that if my insurance company does not reimburse Dr. McBee within 30 days of the service(s) provided to me that Dr. McBee may charge my credit card as provided below at any time from that date forward for any and all unpaid balance for the services that she provided to me regardless of the reason for non-payment by the insurance company. I further understand that Dr. McBee requests this prompt payment of unpaid balances for psychological assessments because Dr. McBee has provided a report to a physician, patient, or other entity requesting the evaluation prior to the 30-day deadline detailed earlier in this agreement and thus the individual who received the service(s) has obtained the benefit of the service prior to that deadline. I understand that if my insurance company makes a payment(s) for the service(s) rendered to me before the 30 day deadline then that payment(s) will be deducted from my balance and I will only be charged the amount remaining, but if payment is made by the insurance company after the date that my credit card was charged for an unpaid balance then the payment made by the insurer will be applied to your account and the excess payment returned to you by check from Dr. McBee. I understand that Dr. McBee uses the credit card company "Square" so that on my credit card statement the charge will appear as "**SQ Norlydia F. McBee, Ph.D.**" or some variation of Dr. McBee's name and I understand that I may not be notified before my credit card is charged and that I may not receive a receipt for the charge other than it appearing on my credit card statement. I further understand that Dr. McBee will add a *surcharge of $10* for credit card processing to any amount/balance charged to my credit card. I also agree that this form is valid for 3 years unless I cancel the authorization in writing. I further agree that Dr. McBee may change the credit card company used to process the charges for her services from the one noted above without notice.

_____ _____
Patient Name Cardholder Name *(if different from the patient)*

_____ _____ _____
Cardholder's Street Address City Zip Code

_____ _____
Credit Card Number Type of Card (Visa, MC, Discover, AmEX)

_____ _____
Expiration Date Security Code *(3 digit – back of card / 4 digits front - AmEX cards)*

_____ _____
Signature ***Date***

Norlydia McBee, Ph.D.
Clinical Psychologist
P. O. Box 217
Carrollton, Georgia 30112

PATIENT INFORMATION ABOUT TELEHEALTH SERVICES

To access a video session with me, you can either use this link to get to the *Virtual Office* (https://doxy.me/mcbee) or you can access it from the *Virtual Office* page at my website (https://drmcbee.com/telehealth). There is nothing to download. When you reach the session page, you will put in your name (however you wish) and the password that I will email to you before your session.

You will need a computer, laptop, tablet, or phone that can connect to the internet and has a camera and microphone (*most do*). If using a PC, you will need to use either the Google Chrome or Firefox browser (although most computers will have at least one of these, they are quick and free downloads and are linked at the *Virtual Office* page on my website).

Please remember:

- Confidentiality still applies for telepsychology services, please do not record sessions.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- You should use a secure internet connection rather than public/free Wi-Fi.
- Close any unnecessary programs and applications and turn off notifications on your computer or device before joining a Telehealth call so as not to disrupt our session.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the me in advance by phone (or email for telehealth sessions only).
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

Payments for sessions and other services can be made directly during the session by credit card or you can discuss payment other options with me prior to your session.

Dr. Norlydia Fulbright McBee
Licensed Clinical Psychologist
200 Glen Eagles Court, Ste. 9B
Carrollton, GA 30117
(770) 834-0995

Telepsychology via Video Conferencing Agreement

It may be possible for treatment delivery to occur via interactive video-conferencing (telehealth) in lieu of, or in addition to, "in-person" sessions. "Telehealth", another name for video conferencing (VC), is a real-time interactive audio and visual technology that enables clinicians to provide mental health services remotely. Treatment delivery via VC may be a preferred method due to convenience, distance, or other circumstances. Research studies have found therapeutic outcomes via VC can be equivalent to those via in-person therapy for many clinical issues; the treating clinician must consider a variety of factors to decide if VC is an appropriate treatment modality for each individual patient (a decision that may change over time if information changes). Dr. McBee reserves the right to decide it is no longer appropriate to engage in sessions via VC at any time for any reason. If this happens, you may need to come for in-person sessions or you may decide you would like to transfer to another clinician in your local area. Regarding insurance coverage, Dr. McBee or her billing staff will make an effort to obtain accurate information regarding your insurance coverage for VC sessions, but you should confirm with your insurance company that the telehealth sessions will be reimbursed as you are responsible for full payment for your session if they are not paid by your insurer. There are potential risks and benefits of VC that differ from in-person sessions, such as potential limits to patient confidentiality and difficulties interpreting non-verbal communication. Confidentiality still applies for telepsychology services and by signing this agreement you are agreeing that you will not record the VC session.

The VC systems that Dr. McBee currently uses are Doxy.me and THERAPlaform and both systems meets HIPAA standards of encryption and privacy protection. But since Dr. McBee cannot control your environment, she cannot guarantee your privacy in your space. You will <u>not</u> have to purchase anything, you only need to be able to sign into a website from your laptop, PC, tablet, computer, or mobile phone and to have a secure connection to the internet. The VC systems work best when you are able to connect to the Internet and retain the connection. It is possible that Dr. McBee may change the VC system she uses in the future (and if that should occur you will be provided with the new that information verbally).

To maximize the usefulness of VC, please think of it as you would an in-office appointment – that is, you write down and protect that time slot and have a place ready for the session that is free from distractions. Consider who may be in the vicinity to hear or see you as you engage in a VC session. If you have any concerns about your data usage charges, please check with your internet or phone carrier as Dr. McBee cannot be responsible for any data usage charges you may incur. If, for whatever reason, you are not able to establish a VC connection at your scheduled session time you will be responsible for paying the missed session fee. If for some reason Dr. McBee has technical difficulties preventing VC connection at your scheduled session time, you will not be charged for the session, provided the connectivity problems persist for at least one third of your allotted session time.

Please write below the names and telephone numbers of your local emergency contacts. This is requested of all patients. By signing this agreement, you are stating that you are aware if Dr. McBee believes you may be at risk for harming yourself she may choose to contact the people listed below to request assistance in assessing your safety risk. By signing below, you are also acknowledging that Dr. McBee may contact the necessary authorities in case of an emergency (such as calling the police to request a "wellness check"). You also agree that if you or Dr. McBee believe that you are in imminent danger of harm to yourself or to another person, you will seek care immediately through you're a local healthcare provider, going to your nearest hospital emergency department, or calling 911.

Address and contact number where you expect to be for your VC sessions:

Street:_____

City:_____ State:_____ Zip:_____

Best telephone number to reach you is: _____

Your psychiatrist or primary healthcare provider:

Name: _____

Phone #:_____

Family member or Friend's name & relationship to you:

_____

Phone #: _____

By signing this document, you are declaring that you have read both *pages of this document and have had the opportunity to ask questions and that understand the risks/limitations and benefits/ and optimal conditions for use of Video Conferencing (or telehealth).*

Patient Printed Name: _____

Signature: _____

Signature Date: _____

If for minor,

Patient Printed Name: _____

Guardian/Parent's Name: _____

Guardian/Parent's Signature: _____

Signature Date: _____

Dr. Norlydia Fulbright McBee
Licensed Clinical Psychologist
200 Glen Eagles Court, Ste. 9B
Carrollton, GA 30117
(770) 834-0995

Permission to Charge Credit Card

When I, _____, am not present to pay in person at the time of service to Dr. McBee, she may charge any fees associated with me that are in addition to insurance (such as a copay) or outside of what is allowed or covered by my insurance to the credit or debit card listed below. Such charges during my absence include telehealth appointments and charges for missed sessions not cancelled within 24 hours of the appointment time. All major credit cards are accepted: Visa, MasterCard, AMEX, and Discover Card, as well as are most health savings account cards and flexible spending cards.

Name on Card: _____

Enter entire credit card number: _____

Billing Address on Card:

Street:_____ City:_____

State:_____ Zip: _____

Expiration Date of Card: ___/____/____ CVC Code on back of card: __ __ __

(AmEx has a 4 digit code)

Cardholder Signature: _____

Date: _____