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.
Clinical Psychologist
200 Glen Eagles Court, Ste 9B
Carrollton, Georgia 30117

Information, Authorization, And Consent to Treatment

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

BACKGROUND INFORMATION

I am a licensed Psychologist in Georgia (and previously licensed in Alabama and Tennessee). To obtain that license, I competed a B.A. in Psychologist at Kennesaw State University and a M.S. and Ph.D. from Auburn University. I also completed a 1-year pre-doctoral supervised year at the University of Alabama at Birmingham and a 1-year post-doctoral supervised training year. I have been practicing as a Clinical Psychologist since 1993 and so I have over 25 years' experience. In addition, I complete 40 hours of continuing education training bi-annually. If you have any questions, feel free to ask!

CONFIDENTIALITY POLICIES

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept on my password protected computer in an encrypted file format. Confidentiality is the legal right to privacy for all clients who receive psychological services. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release by you for a third party (like your physician) or as required by law. However, understand that all information discussed in this office will remain confidential except under the following circumstances:

- A breach of confidentiality is required or permitted by law. Examples include instances in which I have a reasonable suspicion of child abuse, elder/dependent adult abuse, dangerousness toward self or others, and other matters subject to law.
- In my discretion decides to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your bill being turned over to a Collection Agency or submitted to Small Claims Court (requiring the release of your information).
- I use a billing service whose employees will be provided information about you in order to file insurance claims and obtain payment for the services provided to you.
- If you are a party in litigation, including divorce and workman's compensation litigation, and you use your mental condition as an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. I may be required to produce your records and/or testify at deposition or trial if I am served with subpoenas or court orders.
- I may use a cellular phone, email, or other technologies to contact you. However, they have no guarantee of privacy. * *Check whether you authorize contact by these technologies: YES* ☐ *NO* ☐

_____
Please Initial Here

PROFESSIONAL RELATIONSHIP

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. In contracts, a psychologist offers you choices and helps you choose what is best for you. A psychologist helps you learn how to solve problems better and make better decisions. A t psychologist's responses to your situation are based on tested theories and methods of change.

You should also know that psychologists are required to keep the identity of their patients confidential. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. And when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

There are also times I may be away from the office to take time to rest and refresh myself, to attend professional and personal workshops and meetings, or to deal with personal health care issues. On rare occasions, I may be unavailable for weeks at a time. When I will need to be unavailable, I will inform you (except in an emergency situation); and if you would prefer I will provide you with the name and number of another mental health professional you can contact if you feel the need to.

NOTE TO PARENTS ABOUT CONFIDENTIALITY FOR ADOLESCENTS AND MINORS 16+

If your minor participates in treatment, please understand the importance of allowing him/her to develop a confidential relationship with me. For me to provide services to your minor, you must agree that most personal information that he or she discusses with me will not ordinarily be shared with you. Rather, I will provide you with general summaries of your minor's progress without private details. However, understand that I am committed to informing you about unusual or dangerous symptoms or behaviors (such as child abuse, suicidality, intentions to harm others, or driving while intoxicated).

PROFESSIONAL SERVICES AND RATES

My professional services and rates are as follows (please note that your out-of-pocket costs, like your copay amount, and the rate they pay providers are rates contracted by your insurer). However, the rate that I bill for services are as follows: Intake Interview (first appointment) is $225 and psychotherapy that is 53-60 minutes long is $210 (a briefer 37-52-minute session is $150). Psychological testing rates vary based on the number of hours required to administer, score, and complete the report. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment. While I am glad to process credit cards and HAS cards for your convenience, there is a $5 processing fee for each credit card processing requested. Please note that there is a $35 fee for any returned checks.

Please note that I do not voluntarily provide court-related services, but if I am required to participate in court proceedings on your behalf (even if required or requested by another party) the charges are as follows: report writing is $200 per hour (prorated) and any other court-related activities (including testimony, preparation for testimony, travel, and depositions) are $350 per hour (prorated). There is a half day minimum charge for court attendance and standby status; a retainer is required in advance.

_____

Please Initial Here

Fees are due when services are rendered. Fees collected are based on information we obtain from your insurance company and is assumed to be accurate. You will be billed for any balance due and balances not paid within 30 days are "past due." If for some reason the credit card that you placed on file with me is no longer valid at the time in which you agreed that I could charge it for an overdue balance, the past due balance may be sent to a collection agency or pursued through Small Claims Court. If such legal action is necessary, the costs associated with collecting the past due amount will be included in the claim and by signing this agreement you agree that those legal fees are your responsibility. In most collection situations, the only information I would release would be your name (or name of the responsible party), the nature of the services provided, and the amount due.

CANCELLATION POLICY

If you are unable to keep an appointment, you must notify me *at least* 24 hours in advance. There will be a $135 charge for any late cancellations or missed appointments that are not based on a verifiable emergency (for example, your child is in the emergency room). I have set aside a significant amount of time for you and am relying on you to be respectful of my time and professional services as I am respectful of your time and needs as my patient. Please note that insurance companies do not reimburse for missed sessions.

INSURANCE CLAIMS

I will try to assist you in obtaining the insurance benefits to which you are entitled; but the ultimate responsibility for full payment of my fees for services rendered is yours (not that of your insurance company). My billing representative and I will do our best to obtain the necessary authorizations, if any, for your treatment; however please understand that an authorization is not a guarantee of payment by your insurance company. If you have any questions about your mental health coverage, please call your plan administrator or your insurance carrier.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Although it does not happen often, the insurance company may request records (such as a treatment plan, treatment summary, or evaluation results). While the insurance companies claim to keep such information confidential, understand that I have no control over what your insurance company does with your records.

DISPARAGEMENT

The importance of trust and partnership between a psychologist and a patient is hard to overstate. For that reason, I ask that in exchange for my agreement to provide you with the best treatment that I know how to provide, you agree to not to make any oral or written statements (such as emails, talking to friends, or use of online review sites such as Yelp and WebMD), or take any other actions *whatsoever*, to disparage, discredit, libel, abuse, harass, defame, or sully me or to commit any other action that could likely injure, hinder or interfere with my practice as a mental health professional. For this section, "disparage" shall mean any negative statements, reviews, comments, or feedback, whether written or oral, about me.

Healthcare practices are unlike other kind of business in many ways, but one is that they are unable to defend themselves from unfair or untrue statements made against them. For example, healthcare professionals are prohibited from responding to negative statements made against them online or elsewhere due to strict privacy and confidentiality laws (like HIPAA). Every other type of businessperson is allowed to respond to, retort, or deny statements and assertions made by those with whom they do business. In contrast, healthcare providers are forbidden to do so and therefore are not offered an equal level of protection. By signing this agreement, you are stating that you understand the important differences between healthcare professionals and other

_____

Please Initial Here

types of businesses and merchants. You further agree that for each instance of breach of this agreement will incur separate damages and the associated attorney's fees and legal costs required for me to collect the monetary damages.

If you have a concern regarding my services, please speak to me about it (even if that is years in the future). I am always happy to discuss almost any topic with my patients. However, acts of passive aggression, such as disparaging someone to others, is not the most appropriate way to deal your concerns.

IN CASE OF AN EMERGENCY

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours (although this may be longer on weekends, holidays, or vacations). You can also email me at drmcbee@dmcbee.com. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL at 800-715-4225
- Call Willowbrooke at Tanner (Villa Rica) at: 770-812-3266
- Call Ridgeview Institute at 770-434-4567
- Call 911.
- Go to your nearest emergency room.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I can target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

For therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are able to face life's challenges in the future without me. I also don't believe in creating dependency or prolonging

_____

Please Initial Here

therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

OUR AGREEMENT TO ENTER INTO A THERAPEUTIC RELATIONSHIP

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form. By signing below, you also are stating that you have been given an opportunity to read and copy the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you. Please ask any questions that you have and discuss them with me prior to beginning services.

By signing below, I indicate that I understand and agree to comply with the policies, consents, authorizations, and agreements of this office as outlined in this document.

Name (Printed)	***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
Phone 770.834.0995 Fax 770.834.0935

Credit Card Guaranty of Payment

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 (such as fees for phone consultations greater than 15 minutes and missed appointments/late cancellations). I also understand that to assist me in receiving payment from my insurance company for covered charges, Dr. McBee and/or her representatives contacted my insurance company to obtain my insurance information prior to my initial visit so that she can provide me with an estimate of the cost and that she relies on the information provided to her by my insurance company to provide this estimate. I understand that Dr. McBee will be billing my insurance company for those psychological services that are covered by insurance and that she will wait a reasonable amount of time to be reimbursed by my insurance carrier for services delivered that are covered by insurance. However, I understand that sometimes insurance companies do not pay in a timely manner and sometimes they do not reimburse at the rate and in the way that was initially expected and/or that the information initially obtained from the insurance company is sometimes in error. Because of this, I am giving Dr. McBee permission to charge my credit card as provided below for any services (those covered and not covered by insurance) that have not been paid by me or my insurance carrier within ninety (90) days of billing. If services have not been paid within sixty (60) days, Dr. McBee will notify me that a balance is owed by sending a bill to my address of record, thus giving me an opportunity to contact my insurer if the billed amount is due to a lack of payment by my insurance company to ask them to pay for the services in a timely manner. However, 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. I further agree that if my outstanding balance is the result of a late or missed appointment fee(s), that the time allowed will be thirty (30) days rather than sixty (60) days prior to the time I will be sent the notice of intent to bill my credit card for the balance due on my account since insurance is not billed for those charges. 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 agree that I will likely not receive a credit card receipt for this charge from Dr. McBee because the charge will be outside of my presence). 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 understand that this form is valid for 3 years unless I cancel the authorization in writing. I 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: _____