John J. Parrino, PhD

BUSINESS POLICY

FEES:

Psychotherapy: The fee for a regular 50 minute session is $230.00, which is to be paid in full at the time of your appointment. In the event of a fee change, written notice will be provided one month in advance to ongoing clients.

Adult ADHD Assessment: The fee for an ADHD Assessment is $345.00 which is to be paid in full at the time of your appointment.

I am not a participant in any insurance network. If you choose to do so, you might want to file for whatever coverage is available to you. At the end of each session you will receive a form for your personal records, as well as a copy of that form should you decide to submit for insurance or flexible spending reimbursement.

CANCELLATIONS:

Missed appointments or appointments that are not canceled **at least 24 hours** in advance will be charged for the time reserved for you. There is 24 hour -7 days a week telephone coverage for messages.

Please note that Dr. Parrino practices independently, is not in partnership with the other psychologists in the office, and therefore shares no professional liability.

I understand that all charges are due at the time service is rendered, and that I am fully responsible for all charges incurred. I am responsible for missed appointment charges at the full rate of $230.00 unless Dr. Parrino is notified 24 hours in advance.

_____ _____

Signature Date

6100 LAKE FORREST DRIVE o SUITE 115 o ATLANTA, GEORGIA 30328
PHONE (404) 843-1612 o FAX (404) 843-0948

CONSENT TO TREATMENT

This form is to document that I/we, _____ give my permission and consent to the above clinician to provide psychological services to me and/or my spouse/child/children _____.

While I expect benefits from this treatment I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes which could be distressing.

I understand that this therapist is not providing an emergency service and that it is my responsibility to ask how emergency services can be obtained, if necessary, from other sources.

I understand that conversations with the psychologist generally are confidential. However, I understand that the psychologist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the psychologist has a legal responsibility to protect anyone threatened with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the psychologist will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I know of no reason why I/he/she/we should not receive these services and agree to participate fully and voluntarily.

Signature: _____ Date: _____
(of patient or a person authorized to consent for patient)

Date: ____/____/____ DX: _____

CLIENT INFORMATION SHEET

CLIENT(S)

Name: _____ Birthdate: ____/____/___

Name: _____ Birthdate: ____/____/___

Address: _____ Home: (_____) _____

City: _____ State: _____ Zip:_____ Cell Ph:(_____) _____

Cell Ph: (_____) _____

School or Employer: _____ Work Ph: (_____) _____

School or Employer: _____ Work Ph: (_____) _____

Referred by: _____

Other people living in the home (spouse/parents/children/siblings/other)

Name	Age	Relationship to client	Cell Phone

Emergency Contact

Name: _____

Address: _____ Home or Cell Ph: (_____) _____

City: _____ State: _____Zip:_____ Relation to Client: _____

Acknowledgement of Receipt of Notice of Privacy

I, _____, have received a copy of Dr. John J. Parrino's Notice of Privacy Practices.

_____ _____

Signature of Client Date

John J. Parrino, PhD
6100 Lake Forrest Drive, Suite 115
Atlanta, GA 30328

Telephone: (404) 843-1612
Fax: (404) 843-0948

Authorization for Release of Information

I hereby authorize John Parrino, PhD to **release information** to and **obtain information** from:

Name/Organization: _____

Phone No. _____

Regarding **Psychotherapy Notes and Medical Records** contained in the record of:

Client (s) _____

Date of birth: _____

The information is needed for the purpose of **Assessment and Treatment**

I authorize John Parrino, PhD and/or members of his staff to furnish information to the above-named person, organization or its agents, and I further agree to indemnify and hold harmless John Parrino, PhD and his staff from all liability that may arise from the release of the information herein requested. Any information obtained from this authorization should not be re-released to any other persons unless I so specifically authorize. However, once the information is released as I am requesting, I understand that neither John Parrino, PhD, nor his staff have any control over further management of the records so released.

I understand that the records released may contain alcohol and drug treatment information, abuse, as well as psychological information.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken, and that this authorization is valid for a period of **one year** from the date of my signature.

I understand that treatment is not conditioned on my signing this form.

_____ _____
Signature **Date**

_____ _____
Signature **Date**

_____
Parent or Guardian (if applicable)