

Ben C. Ghozali, Psy.D., P.A.
Licensed Psychologist

Patient Information

Today's Date: _____

1. IDENTIFYING INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Pager/Cell: _____

Social Security Number: _____ - _____ - _____

Who referred you? _____

If patient is an adult, spouse/significant other:

Name: _____ Phone # _____

Relationship Status: _____

2. PRIMARY CARE PHYSICIAN/PEDIATRICIAN

Doctor's Name _____ Phone: _____

May I contact your medical doctor so he/she can be fully informed and coordinate treatment?

___ Yes ___ No

3. CURRENT EMPLOYER/SCHOOL

Employer/School: _____ Length of Time/Grade: _____

City: _____

4. INSURANCE INFORMATION

Policy Holder: _____ Employer: _____

Relation to Patient: _____ Birth Date of Holder: _____

Holder's SS#: _____ Address (if different): _____

Insurance Company: _____ Phone #: _____

Policy Number: _____ Group #: _____

5. IF PATIENT IS A MINOR

Mother/Guardian: _____ DOB: _____ Marital Status: _____

Address: _____ City: _____ Phone: _____

Employer: _____ Phone: _____

Father/Guardian: _____ DOB: _____ Marital Status: _____

Address: _____ City: _____ Phone: _____

Employer: _____ Phone: _____

Other Parental Figures: _____ Phone: _____

6. Health Issues and Medications:

7. Emergency Contact:

Name: _____ Phone: _____ Relation: _____

Address: _____ City: _____ Zip: _____

8. _____
Print Name

Signature

Office use only:

of clients in session: _____ Insured in session: _____ CD?: _____ Whose: _____

Primary DX: _____ Secondary DX: _____

**NOTICE OF PRIVACY PRACTICES
SUMMARY OF NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Ben C. Ghozali, Psy.D., P.A. keeps medical information about you. This information is personal and private. We need to use this information in many ways. First, we use the information when we treat you or refer you for treatment. Second, we use the information to pay bills for your medical care. Finally, we use this information for our health care operations and quality assurance.

Under the law, each patient has certain rights to the medical information kept at 1251 S. Myrtle Avenue, Clearwater, Florida 33756. The rights are:

- Access. You can ask to look at your information
- Restriction. You can ask to limit who sees your information. You can ask to limit what information is sent out.
- Accounting. You can ask to see the list of places where your information has been sent.
- Amending. You can ask to change medical information if it is wrong.

A complete notice with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following:

- in person at our office.
- or by telephone at (727) 449-2628

A client also has the right to file a complaint regarding privacy with the Secretary of Health and Human Services toll free 1-877-696-6775. For further information contact our privacy official.

Florida Statutes Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida also has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

Patient signature _____ **Date** _____

Effective date of policy 07/01/09

TREATMENT CONSENT, OFFICE POLICIES AND CONFIDENTIALITY

Treatment Consent

I consent to treatment for myself/my child with Dr. Ben C. Ghozali. I understand that although positive outcomes cannot be guaranteed, it will be strived for. However, Dr. Ghozali may refer me elsewhere should he believe that I would be better served by another provider/agency.

Appointments

All appointments are scheduled by the office manager, Joyce Dion. In urgent situations, the earliest available appointment will be offered. If you must cancel an appointment, please do so with 24-hour notice. You may be charged for missed appointments.

Fees for Services

The fees for services are as follows:

A. Psychotherapy/Consultation

\$175.00 - 50 minute initial interview

\$145.00 - 45-50 minute subsequent sessions

Please be aware that the following services are not covered by insurance.

These services include any written correspondence by Dr. Ghozali to schools, physicians, employers, etc., questionnaires administered to children/parents or teachers, and psychological evaluations.

Written Correspondence

- **Letters** stating a diagnosis and/or a treatment recommendation. **\$25.00**
- **Clinical Summaries** – Letters which summarize and explain a patient's treatment history and current status. **\$40.00-\$75.00**

Psychological Questionnaires

Dr. Ghozali frequently uses a variety of psychological questionnaires which assist him with diagnosis and treatment. Each questionnaire is scored and interpreted. **\$25.00 each**

Psychological Evaluations

- **Intelligence (IQ) Testing** **\$395.00** (includes written report)
- **Personality Testing** **\$295.00-\$595.00** (includes written report)

IV. Telephone Consultation

Dr. Ghozali's office manager, Joyce, is available to answer most questions regarding policies and procedures. In case those questions are not readily answered, Joyce is usually able to respond to questions/concerns after consulting with Dr. Ghozali. **Please be aware that Dr. Ghozali does not provide parent consultation/conference via telephone or internet.**

Insurance/Payment Issues

Insurance companies are entitled to any medical or other information necessary to process insurance claims. Signature on File is to be used on all insurance submissions. The provider and/or office manager may assist in obtaining payment from the insurance company. The insurance payment is to go directly to the provider and the insurance co-payment is due at the time of service.

Clients without insurance are expected to pay in full at the time of the service unless other arrangements are made with this office.

If your insurance payment is not received within 90 days, or if the amount paid by your insurance is less than expected, you will be responsible for the total amount remaining.

For services rendered to a minor dependent, the parent who signs this form is the one responsible for the balance.

There is a \$25.00 fee for any returned checks.

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions.

- A. The therapist believes that the client plans to harm himself/herself or another person.
- B. The client is a minor (under 18) and reports suspected child abuse.
- C. The client reports abuse of the elderly.
- D. If the client fails to pay the balance in full within a reasonable amount of time, some confidential information may be released so that collection of the fees may be pursued through an outside agency.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

If you have any questions regarding the above agreement, please feel free to speak with Joyce or Dr. Ghozali. I agree to these policies and consent to treatment.

Signature

Date