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

Patient Information

Date: ___________________

IDENTIFYING INFORMATION

Name: _________________________________ Date of Birth: ________________ Age: ____________

Address: ____ City: ____________________ Zip: __________

Home Phone: _____________Work Phone: _______________ Pager/Cell: _________________

E-mail Address:_________________________________

Social Security Number: _________ - ______ - ____________

Who referred you? __________________________

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

1. CURRENT EMPLOYER/SCHOOL

Employer/School: ___________________________ Length of Time/Grade: ______________

City: _________________________________

INSURANCE INFORMATION

Policy Holder: __________________________ Employer: __________________________

Relation to Patient: _____________________ Birth Date of Holder: ____________________

Holder's SS#: _____________________ Address (if different): ________________________

Insurance Company: ___________________ Phone #: _______________________

Policy Number:_______________________ Group #:_______________________

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: ___________________________

HEALTH ISSUES AND MEDICATIONS:
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____
____

EMERGENCY CONTACT:

Name: _____________________________________ Phone: ____________________ Relation: ________________

Address: ___________________________________ City: ______________________ Zip: _______________

____
Print Name

____
Signature

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 611 S. Myrtle Avenue, Suite B, 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
- 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 _____________

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 manage. 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)

Telephone Consultation

Dr. Ghozali's office manager is available to answer most questions regarding policies and procedures. In case those questions are not readily answered, the office manager 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.**

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 the office manager or Dr. Ghozali. I agree to these policies and consent to treatment.

__________________________________ ____________________

Signature Date