DIRECTIONS TO DR. CYNTHIA TURNER'S OFFICE
PARK SOUTH OFFICE COMPLEX
7505 WATERS AVE., SUUITE E-2
SAVANNAH, GA 31406

FROM INTERSTATE 16 AND LYNES PARKWAY (516), MERGES INTO DERENNE AVE.

TURN RIGHT ON WATERS AVE.

DRIVE APPROXIMATELTY TWO MILES

AFTER CROSSING THE EISENHOWER INTERSECTION, LOOK FOR PARK SOUTH OFFICE COMPLEX, 7505 WATERS AVE. ACROSS FROM THE ENMARK GAS STATION.

TURN RIGHT INTO THE PARKING LOT, THEN LEFT TOWARDS BUILDING E.

THE OFFICE IS UPSTAIRS TO THE LEFT, SUITE E-2

FROM INTERSTATE 95, TAKE 204 TOWARDS SAVANNAH, WHICH MERGES INTO ABERCORN STREET.

TURN RIGHT ONTO MALL BLVD.

AT THE THIRD RED LIGHT, TURN LEFT ONTO WATERS AVE.

DRIVE APPROXIMATELY ONE QUARTER MILE.

PARK SOUTH OFFICE COMPLEX ON THE LEFT, DIRECTLY ACROSS FROM THE ENMARK GAS STATION.

Cynthia J. Turner
Licensed Psychologist
7505 Waters Ave., Suite E-2
Savannah, GA 31406
Office (912) 352-8658 Fax (912) 356-5492

Patient Name: ____ Date: ____________

Address: ____

City: __________________________ State: ____________ Zip Code:_____________

Telephone(s): ( ) _______________ ( ) _______________ ( ) ______________
HOME WORK CELL

May we contact you at work? ______________Via Voice Mail? _________________

May we leave messages for you at home? __________Via Voice Mail? ____________

Age: ______ Birth date: ___________ SS #: ________________ Marital Status: _____

Occupation:____

Employer: _____________________________________ How Long:_____________

Education:____

Briefly describe your reason(s) for seeking help:_________________________________

____

____

Who referred you to this office: ____

When were you last examined by a physician? _________________________________

Name of Physician: ______________________________Telephone: ______________

List any major health problems for which you currently receive treatment: ____________

____

List any medications you are currently taking: ________________________________

____

List any psychoactive medications, such as antidepressants, tranquilizers, or mood stabilizers you have taken and when you received such treatment: ____________________

____

Have you ever received psychiatric or psychological help or counseling of any kind before? ___________If so, please explain: _______________________________________

____

____

List the members of your family and all others in your home:

Name	Age	Relationship	Occupation

Name of person(s) to be contacted in case of an emergency:

____ Telephone: ________________________

____ Telephone: ________________________

Please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble

Bowel Troubles Being a Parent My Thoughts

FINANCIAL AND INSURANCE INFORMATION

Party Responsible for payment: ____

Address: ____

City: ________________________ State: ____________ Zip Code: __________

Telephone: ( ) ________________ Social Security Number: ________________

Driver's License Number: __________________________ State: ____________

Employer: ____

Address: ____________________________ Telephone: ( ) _______________

Signature of Responsible Party Date

____

Insurance Company: ________________________ Telephone: ______________

Insurance Company Address: ____

____

Subscriber ID or Policy # ____________________________ Group # __________

Is a preauthorization required? _______If so, name of managed care co.: __________

____

Policy Holder Name: ____

Social Security Number of Policy Holder: _______________________________

Policy Holder Birth Date: ____

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PAYMENT AGREEMENT AND ASSIGNMENT OF BENEFITS

Professional fees are based on $150.00 for a standard fifty (50) minutes session, including the initial diagnostic interview. Psychological assessments, consultations, and reports are billed at $150.00 per hour. **Payment is expected at each visit and should be given directly to Dr. Turner at the time of your visit.** Patients are responsible for payment of the total charges shown on the statement of the account. We cannot guarantee payment by the insurance company. Patients offering health insurance as complete or partial payment of their fees may do so by assigning anticipated insurance payments to Dr. Cynthia Turner. However, your deductible, co-payment, or coinsurance are due at the time of service.

We recommend that you routinely review your explanation of benefits statements which you receive from your insurance company. It is your responsibility to track any errors in payment that your insurance company makes. Please be advised that at termination of treatment, you are responsible for any remaining balance. We file insurance claims as a service for our patients; however, any errors or denial of payments are your responsibility, as are any outstanding insurance co-payments. If you have any questions about your account, please feel free to ask for a detailed ledger of you account.

I herby assign all medical benefits to Cynthia J. Turner, Ph.D. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original**. I understand I am financially responsible for all the charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.**

______________________________ ______________________________
Patient Date

______________________________ ______________________________
Guarantor (if different) Date

______________________________ ______________________________
Witness Date

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APPOINTMENT SCHEDULING POLICIES

All appointments not cancelled at least 24 hours in advance will be the financial responsibility of the patient. This policy is necessary because your appointment time is reserved for you only, and if you are not able to keep it, there may be someone else who would like the time that has been set aside for you, as we usually have a waiting list. **Please initial** __________

We realize that sometimes a 24 hour notice is impossible to give for a very valid reason, including unexpected work related problems and illness. However, we must be fair to everyone, so please accept the fact that you are expected to pay for time you reserve. **Please initial** __________

PLEASE NOTE THAT WE ARE UNABLE TO BILL INSURANCE COMPANIES FOR LATE CANCELLATIONS AND MISSED APPOINTMENTS. BILLING FOR THESE ITEMS IS CONSIDERED INSURANCE FRAUD. YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL SERVICE FEE. IF YOU ARE UTILIZING INSURANCE BENEFITS, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL ALLOWABLE INSURANCE RATE FOR THE SERVICE.

Please initial __________

If you are running late for your appointment, you will receive the remainder of your scheduled appointment, and the full time only if it is available. Either way, you will be charged for the original appointment you booked. **Please initial** __________

If I am running late for your appointment, you may usually receive your full appointment time, or the option of shortening your appointment and paying accordingly. **Please initial** __________

Patients are encouraged to book regular appointments as far in advance as possible in order to ensure the preferred day and time. This advance booking is available for your benefit. If you miss your appointments or need to cancel at the last minute frequently, please speak to me so we can try to work out a suitable arrangement.

Please initial __________

Please note that under some circumstances, Dr. Turner may be able to do a phone session if you have an urgent situation and are unable to make your appointment time. **Please initial** __________

I have read and understand this policy.

__________________________________ ____________________
Signature Date

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Statement of Client Rights and Responsibilities

1. My goal is to always treat you competently, ethically, and respectfully.

2. You can stop seeing me without any obligation other than to pay for services you have received or appointments not cancelled 24 hours in advance.

3. Feel free to ask questions about my approach and methods or to decline any recommendations I make.

4. You can see your records.

5. Our discussions are confidential. This means that, except as noted below, I won't release information that identifies you to anyone without your written permission.

6. In certain situations, by law, I must reveal information about you to others **even without your permission:**

   (a) In emergencies, including the risk that you may harm yourself or others, I'll share information necessary to keep you and others healthy and safe.

   (b) I am obligated to release to a court of law any information specifically described by a court order.

   (c) I will report to the Department of Family and Children Services any reasonable suspicion I have that a minor is being abused or neglected.

   (d) I will release any information necessary to collect any outstanding bill for services rendered to you.

Please show your understanding to the above by signing below.

________________________________ ____________________
Signature of Patient Date

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HIPAA CONSENT FORM

I HAVE READ AND UNDERSTOOD THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WHICH HAS BEEN PRESENTED TO ME BY DR. TURNER.

SIGNATURE: ______________________________

PRINT: ____________________________________

DATE: ____________________________________

I HAVE BEEN OFFERED BUT DO NOT WANT A COPY OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

SIGNATURE: ______________________________

PRINT: ____________________________________

DATE: ____________________________________