Sherri W. Bornstein, PhD

BUSINESS POLICY

FEES:

The fee for a regular 45-50 minute session is $200.00, 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.

INSURANCE:

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 which you might choose to submit for possible 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. Bornstein 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 $200.00 unless Dr. Bornstein is notified 24 hours in advance.

_____ _____

_____ _____

Signature(s) Date

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

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CONSENT TO TREATMENT

This form is to document that I/we, _____,
give my/our consent to the above clinician to provide psychological services to me/us.

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 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 that in couples therapy, Dr. Bornstein is free to reveal to both members of the couple anything discussed in an individual conversation with Dr. Bornstein.

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

_____ _____

_____ _____

Signature(s) Date

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Sherri W. Bornstein, PhD

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: _____

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