Patient Information Form

Informed Consent Notification and Office Policies

Limits of Confidentiality
Psychiatric services delivered remain confidential according to the State of Georgia licensure board.
However, Georgia law requires exception to confidentiality in the following circumstances:

a. A patient expresses intent to inflict life-threatening harm to himself/herself.
b. A patient expresses intent to inflict life-threatening harm to someone else.
c. Current situations in which a minor is experiencing physical and/or sexual abuse, a report must be made to the proper authorities.
d. Patients who utilize their insurance benefits acknowledge that the policyholder will receive billing information for all clinical services rendered.

Initial Interview, Assessment, and Possible Referral
The first appointment for psychiatric assessment and your needs and expectations are discussed, relevant history taken, and a determination is made as to whether our services would be beneficial to you. As a part of this process, certain assessments maybe needed. At times, additional assessments maybe necessary in order to provide relevant diagnostic information. If the services here do not meet your needs or you wish to have psycho therapy, a referral can be made.

Phone Calls/Emergency Contacts
In life or limb threatening emergencies, you should always call 911 or proceed to the closest emergency room. Calling our office first will waste potentially life-saving time. For other emergency needs, a physician is on call 24/7, and during business hours the office staff can be contacted. Unfortunately, many patients abuse phone calls and attempt to get health care via the phone. This is unacceptable for a variety of reasons. As insurance companies will not allow billing for these services, all phone calls for refills or any other issues will be billed at a rate equal to the hourly rate and in a minimum of 10 minute increments rounded up. *This means that the minimum charge for telephone services is $25.00 and may be more depending on the time involved.* These balances will be your responsibility solely and no insurance will cover these costs. Any issue that is clearly determined to be an emergency will not be subject to such billing, and all phone messages will be returned within (1) business day.

Medications
You may be prescribed medications, some are on your personal insurance plan, some not, and some require prior authorizations. Be sure to bring your current list from your insurance carrier if you want to be prescribed an insurance preferred drug. Should you find that your pharmacist requires a prior authorization from your physician, please note, the process may take 3-7 business days so check with your insurance company or pharmacy for the results. Refills are not routinely phoned into a pharmacy at night or over the weekend. Remember to call several days in advance to request a refill of your medications. Certain medications cannot be called in and you will need to keep your appointment in order to stay on the medication without interruption. It is important for you to keep your appointment in order to get a prescription for a refill of those special medications.
Medication refills may be requested weekdays between 9:00 a.m. and 5:00 p.m. and will be called into the pharmacy on the same business day the request is made. Requests after 3:00 p.m. will be recorded on the following business day. When requesting a refill, please provide:

- **Your Name**
- **Your Date of Birth**
- **Name of Medication Requesting**
- **Dosage**
- **Pharmacy Telephone Number.**

Missed Appointments
It is our policy that appointments cancelled less than 24 hours from the scheduled appointment or missed appointments are charged a fee of $75.00. There are no exceptions to this policy so please make sure you give us enough time before your appointment when canceling. Please note that insurance does not reimburse for cancelled/missed appointments.

Returned Checks or Stop Payment Checks
All returned checks will consist in a returned check fee of $35.00. This will be assessed to cover the administrative and other costs involved in recovering amounts related to these checks. Payment for such checks is expected before any further treatment will be rendered. Nonpayment of such funds will be automatic grounds for termination of care and will constitute immediate termination of care with the provision that a 30 day period of emergency only treatment will be provided. Such treatment does not include the

provision of routine refills of medication of routine visits. If payment of the amount of the check is not provided within 10 business days of our having notified parties of the issue, we will file charges in the appropriate jurisdiction.

Termination of Services

At the end of your course of treatment we will discuss the need for future follow-up or when/if it is necessary to resume care. Your records will be maintained for a minimum of seven to ten years or as required by law. These are available for forwarding to another provider or for our use should you resume care with us.

Psychiatric care is a partnership of which you primarily are in control. You have the right to terminate this care at any time and for any reason, but we encourage you to discuss this with your provider prior to making that decision so as to facilitate any transition. Rarely, it becomes necessary for the provider to terminate a working relationship with a client. The following is a non-exclusive list of potential reasons for termination of care with a client: nonpayment of fees, bad checks, chronic missed appointments, abuse of phone calls, abuse of medications, non-compliance with treatment recommendations, abusive language with the provider or office staff, abusive behavior with the provider or office staff, illegal behavior of any sort pertaining to your treatment and behavior that is disruptive or inappropriate in the waiting area. If termination is necessary you will be provided with a list of alternate means of seeking care. Emergency care will only be provided to you for 30 days. This care does not include refills of routine medications (only emergency services). Individual issues around termination will be handled on a case by case basis.

Fees and Services

Our Doctors have a standard fee for services. Payment is expected at the time services are rendered. If you have a co-pay, that fee is to be paid at the time of service by contractual arrangement with your insurance carrier. Although you may have prior authorization for services, it does not guarantee claim payment.

I have read and understand the conditions listed above for receiving services and agree with them.

_____ _____

Signed (Patient or Legal Guardian) Date

GEORGIA BEHAVIORAL Health Professionals

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Disclosure Form

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and can not be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed

I, _____ hereby authorize, Dr. _____ to disclose to:
Patient Name Provider Name

Name below the person and / or organization to which disclosure is to be made

1.

2.

3.

The purpose of the disclosure authorized herein is to:

(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

_____ _____ _____
Signature of Participant (Print Name) Date

_____ _____ _____
Signature of Parent, Legal Guardian (Print Name) Date

Patient Information Form

Notification of Customer Rights

I understand that the laws and regulations governing licensure of mental health and substance abuse treatment programs assure me of certain rights and that these rights apply to me as a client or to my minor child.

1. I have the right to be treated with dignity and respect without discrimination as to sex, race, age, creed, sexual orientation, religion, or national origin.
2. I have the right to have the nature of recommended treatment and any specific risks of such treatment explained fully to me.
3. I have the right to develop my own treatment plan to meet my own specific needs.
4. I have the right to confidentiality. Except as may be required by law, no information concerning me or my treatment, may be given without my consent in writing. I have the right to revoke any given consent with the understanding that any action taken beforehand cannot be retracted or withheld.
5. I have the right to be told if the agency cannot provide the services that I need.
6. I have the right to request restrictions on certain use and disclosure of personal healthcare information (PHI) understanding that the provider is not required to agree to any requested restrictions.
7. I have the right to receive personal confidential communications of protected information as applicable.
8. I have the right to inspect and copy as provided; this does not include psychotherapy notes.
9. I have the right to correct and amend PHI as provided under federal guidelines; however I cannot request clinical data from another clinician to be altered by another provider.
10. I have the right to request an accounting of disclosures of PHI as provided.
11. I have the right to review the policies and procedure manual for HIPAA compliance and further explanation of these rights.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our privacy officer. I acknowledge by signing below that I have read the **Notification of Customer Rights** and understand them. I certify this understanding by signing below.

_____ _____

Signed (Patient or Legal Guardian) Date

Patient Information Form

Notification of Health Information Practices

After reviewing this Notice, if you need further information or want to contact us for any reason regarding handling of your health information, please direct any communication to the following contact person:

Privacy Officer
250 Corporate Center Court,
Stockbridge, GA 30281
770.389.8100

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his (or her) expectations of the treatment. In that way the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy your health record, amend your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. For additional information about our health information practices or to report a problem, you may contact Georgia Behavioral Health Professionals at 770.389.8100.

A full copy of this notice is available from the front desk of Georgia Behavioral Health Professionals or at - www.gabehavioralhealth.com.

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; or calling 1-800-368-1019. There will be no retaliation for filing a complaint to the Secretary of Health and Human Services. We cannot and will not make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize your for filing a complaint with HHS.

My signature below indicated that I have read the notice of privacy practices.

Signed (Patient or Legal Guardian) _____ Date _____

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OFFICE FEES

Please initial next to each fee.

NO SHOW

- $75 If there is not a **24 hour notice** _____

FORMS

- Extensive forms $250 (duplicate $50) _____
- Regular forms $75 (duplicate $25) _____

MISCELLANEOUS FEES

- Prescription Refills $25 _____ (The doctor instructs you when to return for your next office visit. If you cancel, do not show or misplace medication there is a charge for a refill)
- Prior Authorization $10 _____
- Gastric Bypass Surgery ~ $225 _____ (Evaluation done at Physician discretion. Insurance is not accepted)

ACCEPTABLE FORMS OF PAYMENT

- ***CASH*** – We will gladly accept cash, however, change may not be available at all times. We can apply the amount as a credit to your account.
- ***CHECKS*** – **We cannot accept checks larger than $20. There is a $35 fee for all returned checks.**
- ***CREDIT CARDS –*** We accept **ALL** major **credit/debit cards** for your convenience.

If you have any questions regarding the fees please do not hesitate to ask.

I have read and understand the information and fees outlined above.

_____ _____

Signed (Patient or Legal Guardian) Date