Atlanta Area

Family Psychiatry Clinic, PC

Child, Adolescent, Adult and Family Psychiatry
& Psychotherapeutic Services

7000 Peachtree Dunwoody Road
Building 16, Suite 100
Atlanta, Georgia 30328-5754

www.AAFPC.net
Phone (770) 393-1880
FAX (770) 393-1885

BUSINESS POLICY~CONSENT for TREATMENT~PATIENT INFORMATION

Please read this information carefully and discuss any questions you may have with your therapist.

FEES: Regular Office Visits are scheduled for 45 minutes and charged as follows: Psychiatric Physician (M.D.) $220 (initial session, 60 minutes $290); Licensed Psychologist (Ph.D.) $160 (initial session, 60 minutes $190); Licensed Clinical Social Worker (L.C.S.W.) $145 (initial session, 60 minutes $165). Medication only follow up appointments are typically scheduled for 25 minutes ($160.) Extended sessions, consultations are charged at a somewhat higher rate. Forensic services are charged at $375/hour for all time involved in the case. Fees are subject to change; notice will be posted in the front office.

TELEPHONE CALLS: Brief phone calls are not charged. Therapeutic phone calls or medication discussion/changes by phone will be charged.

Rx REFILLS and Rx PRIOR AUTHORIZATION: Use our website, www.AAFPC.net (3rd tab) to request refill authorizations. **Allow FIVE full business days for receipt of mailed Rx's.** We will make every effort to accommodate urgent (same day) Rx refill requests ($15/per request.) Insurance prior authorizations are time consuming and are therefore charged at $25 per medication authorized.

CANCELLATIONS: We ask that if you must cancel an appointment, as a courtesy to your therapist, please do so well in advance through your therapist's voice mailbox (770) 393-1880. **Any apointment that is cancelled less than one business day in advance will be charged for the time set aside for you. Exceptions will need to be discussed with your doctor or therapist.** We do NOT call you to remind you of your appointment. If you are unable to cancel a session in time you may have a phone appointment which is charged at the standard rate.

COMMUNICATION WITH YOUR DOCTOR or THERAPIST: You may leave a message with your doctor or therapist through our voice-mail system, (770)-393-1880. Each therapist checks their mailbox regularly and will make every effort to return your call as soon as possible.

URGENT RESPONSE/EMERGENCIES: You may call our 24-hour, 7 day per week phone answering system at any time if you have an urgent need to contact your therapist (770-393-1880); be sure to use your therapist's urgent mailbox. Our practitioners remain on call virtually 24h/7d-365 days per year. **Since your provider is on call virtually full time, we urge you to be considerate of your provider's willingness to be available.** If for some reason you are not able to reach your provider, you may leave a message with the secretary during business hours to have another staff member return your call. **This availability is NOT FOR EMERGENCIES. In an EMERGENCY, call 911 or go to your nearest emergency care facility for care.**

PAYMENTS: It is expected that you pay for your services at the time of the visit regardless of your insurance coverage. Any exceptions must be arranged through your therapist.

INSURANCE: We do not file insurance claims, however, many services we provide are covered by insurance. Since coverage varies widely from policy to policy, we cannot guarantee that these services will be reimbursed by your insurance carrier. You may file for reimbursement directly with your insurance carrier. At the time of your appointment, your physician or therapist will give you a super-bill. Attach it to the "physician's section" of your insurance claim form and file it directly with your insurance company to obtain any reimbursement. Many of our services are covered under "out of network" benefits.

BILLING: If you have an outstanding balance at the end of the month, you will receive a monthly statement of your account, which is payable on receipt. If your account becomes delinquent, the total amount due will accumulate with interest added at the rate of 1.5% per month until paid in full. Should your account have to be collected through an attorney, you will also be responsible for all reasonable attorneys' fees and all costs of collections.

GROUP PRACTICE MODEL: A significant advantage of being treated in a group practice is the availability of professional consultation with colleagues in the practice about your treatment. Your therapist may discuss your care with other professionals in the clinic. If you have questions or concerns regarding this process, please discuss this with your therapist.

OTHER IMPORTANT FACTORS IN TREATMENT: The success, length and outcome of treatment is affected by many things including the severity of the problem, the match between the therapist and patient, the motivation of the patient, among other factors. Please discuss with your therapist your expectations and feelings about treatment. The best outcome is achieved through collaboration between the patient and provider.

CONSENT FOR TREATMENT/CONFIDENTIALITY: Communication between a patient and a therapist will be held in confidence and will not be revealed to outside agencies without your written consent unless specifically required by law (for example: child abuse, imminent threat of danger to yourself or others, court order, etc.) Group therapy, marital therapy and work with adolescents may involve different legal issues around confidentiality. Please ask if you have concerns about these issues. Information released to insurance companies for reimbursement for services is released only on authorization from you. However, if you waive confidentiality for your insurance company, they may request that your entire record for treatment be released. Please be sure that you are clear about what information your insurance company is requesting before you waive confidentiality.

DISCONTINUATION OF TREATMENT: Typically, the decision to terminate therapy is made as a mutual thoughtful decision involving the therapist and patient. In the event that you discontinue treatment without notifying your therapist, we will assume that your therapeutic relationship with us terminated 30 days after your last visit, unless you have an appointment scheduled for a future date, beyond which we carry no further responsibility for your care. If you have been prescribed any medications, we urge you to not modify your medication program without contacting you psychiatrist first. Abrupt termination of some medications prescribed may have serious adverse effects on your health. Please discuss any medication changes with your physician including medications added or changed by you or other medical providers outside AAFPC.

COMMUNICATION WITH OTHER PROFESSIONALS:

May your therapist discuss your care with your referring professional? Yes ___ No ___

Referring Professional: _____ Telephone (_____) _____-_____

Address: _____ City: _____ State: ____ Zip: _____

Please sign acknowledging that you accept these policies and have kept a copy for your records. If you have any questions or issues to resolve about any business matters, please discuss them with your therapist or ask any of our office personnel (Sandy, Helen or Joan.)

Responsible Party Signature/Information: I acknowledge that I have read and accept this policy and consent for treatment of myself or my minor child listed herein and accept responsibility for all fees incurred. I have also had on opportunity to review and have been offered a copy of the "HIPAA NOTICE OF PRIVACY PRACTICES" policy. If the patient is a minor child I acknowledge that I have the legal authority to consent for treatment of this child.

Date: _____/_____/_____

Responsible Party Printed Name: First: _____ MI: _____ Last: _____

SSN: __ __ __ -__ __-__ __ __ __ DOB: _____/_____/_____ If not patient, relationship: _____

Patient's name: _____ Patients DOB: _____/_____/_____

Street: _____; Apt: _____

City: _____; State: _____; Zip; _____

Home: (_____) _____-_____; Work: (_____) _____-_____; Cell: (_____) _____-_____

Responsible Party Signature: _____ Date: _____/_____/_____

Please circle Doctor/Therapist to be seen: Ashley, Fadia, Gard, P. Hart, W. Hart, Iwanicki, Kanawati, LeDuc, Mette, E. Slayden, R. Slayden, Waugh

Therapist's data sheet:

Date: _____/____/_____

Patient Name: _____ DOB: ____/_____/_____ Age: __ SEX: M F

Address: _____ Home: (_____) _____-_____
_____ Cell: (_____) _____-_____
City: _____ State: _____ Zip: _____ Work: (_____) _____-_____
Sex: M / F Religion: _____ Occupation/School Grade: _____
If you are filling out this form, and are not the patient, what is your relationship to the patient? _____
Please describe reasons for seeking care: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Patient's Medical/ Surgical/ History: _____
_____
Medications/dose/how taken: _____
_____
_____
Please list all other immediate family members below:

1. Name: _____ Relationship to Patient: _____
   DOB: ____/_____/_____ Age: _____ Religion: _____ Occupation/School-grade: _____
   Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____
   _____
   _____
2. Name: _____ Relationship to Patient: _____
   DOB: ____/_____/_____ Age: _____ Religion: _____ Occupation/School-grade: _____
   Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____
   _____
   _____
3. Name: _____ Relationship to Patient: _____
   DOB: ____/_____/_____ Age: _____ Religion: _____ Occupation/School-grade: _____
   Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____
   _____
   _____
4. Name: _____ Relationship to Patient: _____
   DOB: ____/_____/_____ Age: _____ Religion: _____ Occupation/School-grade: _____
   Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____
   _____
   _____
5. Name: _____ Relationship to Patient: _____
   DOB: ____/_____/_____ Age: _____ Religion: _____ Occupation/School-grade: _____
   Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____
   _____
   _____