AAFPC BUSINESS POLICY / CONSENT for TREATMENT / PATIENT DATA

Atlanta Area

Family Psychiatry Clinic, PC

Child, Adolescent, Adult and Family Psychiatry & Psychotherapeutic Services

7000 Peachtree Dunwoody Road **www.AAFPC.net**
Building 16, Suite 100 **Phone (770) 393-1880**
Atlanta, Georgia 30328-5754 **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 doctor/therapist.

FEES: Regular Office Visits are scheduled for 45 minutes and charged as follows: Psychiatric Physician (M.D.) $260 (initial session, 60 minutes $350), Medication only follow up appointments are typically scheduled for 25 minutes: $185; Licensed Psychologist (Ph.D.) $200 (initial session, 60 minutes $225); Licensed Clinical Social Worker (L.C.S.W.) $165 (initial session, 60 minutes $175) Extended sessions and consultations are charged at a somewhat higher rate. Forensic services are $395/hour for all time involved in the case.
Fees are subject to change; notice will be posted in the front office. All fees are payable in advance on the date of service.
TELEPHONE CALLS: You may leave a message with your doctor or therapist through our voice-mail system, **(770)3931880**. Each therapist checks their mailbox regularly and will make every effort to return your call as soon as possible. There is no charge for **brief** phone calls. Therapeutic phone calls, calls longer than a few minutes or medication discussion/changes by phone will be charged according to the time and level of service involved.
URGENT RESPONSE: Your provider has a 24-hour, 7 day per week urgent response mailbox **(770)-393-1880 plus you provider's extension**. If you have an urgent (**non-emergency**) need to contact your therapist; be sure to use your therapist's urgent mailbox. Our practitioners remain on call virtually 24/7-365 days per year. **Since your provider is on call essentially 24/7 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 provider return your call.
EMERGENCIES: This availability is NOT FOR EMERGENCIES. In an EMERGENCY, call 911 or go to your nearest emergency care facility.
EMAIL: For security and privacy/confidentiality reasons, we do not use email for therapeutic communications so **please do not email us medication questions/change requests, symptom/issue discussions, or appointment changes/cancellations. All of these matters should be handled by leaving a voice mail with your therapist**. You may request our email address to send third party documents or test reports to your provider. The front office staff handles any emails received and distributes printed copies to the recipient. Please notify the secretary prior to sending any documents. We will assume that you wish us to review documents submitted. Any time spent reviewing documents sent will be charged at our standard rates according to time spent.
Rx REFILLS and Insurance 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 ($25/per request.) Insurance prior authorizations are time consuming and are $35 regardless of approval.
CANCELLATIONS: 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 appointment that is**

cancelled less than one business day in advance will be charged for the time reserved for you as your provider would be unable to assign the time to someone else. Exceptions will need to be discussed with your doctor or therapist. **We do NOT call 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. Note that some insurance companies may not pay for phone sessions.

PAYMENTS: It is expected that you **pay for your services on arrival for your appointment** 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 as "out of network benefits." 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.

BILLING/OUTSTANDING BALANCES: All fees are payable in advance on the date of service. If you should 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 it is paid in full. Should your account have to be collected through an attorney or our collection agency, you will also be responsible for all reasonable attorneys' fees and all costs of collections. In the event that your account is placed with a collection agency, a collection-fee in the amount of 7% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will also be responsible for all costs of collection including attorney fees and court cost. You agree, that if we should need to collect any amounts you may owe, we and/or our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or our collection agencies may also contact you by sending text messages or email messages, using any email address or telephone number you have provided to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MINOR PATIENTS TURNING to ADULT AGE: As grantor of payment for this patient, I accept responsibility for any and all charges incurred by this patient regardless of patient reaching age of majority unless rescinded by me in writing to Atlanta Area Family Psychiatry Clinic, P.C.

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 released without your written consent unless specifically required by law (for example: suspected child abuse, imminent threat of danger to yourself or others, or court order.) 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.

DISCONTINUATION OF TREATMENT: Typically, the decision to terminate therapy is made as a mutual thoughtful decision involving the therapist and patient. If you discontinue treatment without notifying your therapist, we will deem 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. Sudden 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 our secretaries (Sandy or Cindy.) **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.**
Unless you indicate otherwise, you acknowledge that we may contact you at any of the numbers you have provided. If you do not wish to be contacted please indicate here ( ). If you do not allow contact, you may not receive important clinically relevant communications from us.

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: (_____) ______-_________

Email: ____@_______________________________._______
Responsible Party Signature: _______________________________________ Date: ____/_____/________

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Please circle Doctor/Therapist to be seen: L. Ashley, B. Gard, P. Hart, W. Hart, T. Iwanicki, S. Kirsch, L. Mette, S. Neely, L. Perez, E. Slayden, R. Slayden, L. Waugh

Patient Name: F: _______________ L: ________________ DOB: ____/______/______ Age: ___ SEX: M F

Address: ____ Home: (______) ______-________________

____ Cell: (______) ______-_________________

City: ____________________________ State: ___ Zip: ________ Work: (______) ______-_________________

Religion: _____________ Occupation/School Grade: ____

Parent/Guardian if not patient: __________________________________ Relationship: __________________

Please describe reasons for seeking care: ____

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Patient's Medical/ Surgical/ History: ____

____

Medications/dose/how taken: ____

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Please list all other immediate family members below:

Name: F:____________________ L:__________________________ Relationship to Patient: _________________
DOB: ____/______/______ Age: _____ Sex __Religion: _______ Occupation/School-grade: _______________
Lives at home? Yes / No; Medical/Surgical/Emotional Problems: ____

____

Name: F:____________________ L:__________________________ Relationship to Patient: _________________
DOB: ____/______/______ Age: _____ Sex __Religion: _______ Occupation/School-grade: _______________
Lives at home? Yes / No; Medical/Surgical/Emotional Problems: ____

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Name: F:____________________ L:__________________________ Relationship to Patient: _________________
DOB: ____/______/______ Age: _____ Sex __Religion: _______ Occupation/School-grade: _______________
Lives at home? Yes / No; Medical/Surgical/Emotional Problems: ____

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Name: F:____________________ L:__________________________ Relationship to Patient: _________________
DOB: ____/______/______ Age: _____ Sex __Religion: _______ Occupation/School-grade: _______________
Lives at home? Yes / No; Medical/Surgical/Emotional Problems: ____

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Name: F:____________________ L:__________________________ Relationship to Patient: _________________
DOB: ____/______/______ Age: _____ Sex __Religion: _______ Occupation/School-grade: _______________
Lives at home? Yes / No; Medical/Surgical/Emotional Problems: ____

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Please initial to acknowledge acceptance of policies in these pages_____