

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

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 doctor/therapist.

FEES: Regular Office Visits are scheduled for 45 minutes and charged as follows: Psychiatric Physician (M.D.) \$275 (initial session, 60 to 90 minutes \$370 to \$450 depending on scheduled length of appointment), Medication only follow up appointments are typically scheduled for 25 minutes: \$195; Licensed Psychologist (Ph.D.) \$200 (initial session, 60 minutes \$225); Licensed Clinical Social Worker (L.C.S.W.) \$175 (initial session, 60 minutes \$190) Extended sessions and consultations are charged at a somewhat higher rate. Forensic services are \$450/hour for all time involved in the case.

Fees are subject to change; notice will be posted in the front office. All fees are at the time of service.

TELEPHONE CALLS: 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. There is no charge for **brief** phone calls. **Therapeutic phone calls, calls longer than a five 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, which may be used for **urgent (non-emergency)** needs. **Since your provider is on call essentially full time, we urge you to be considerate of your provider's time.** If for some reason you are not able to reach your provider, you may contact one of the secretaries during business hours to have another provider return your call.

EMERGENCIES: If you have an EMERGENCY, call 911 or go to your nearest emergency care facility. Urgent voicemail is not for emergencies.

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: To request a prescription refill, use our website, www.AAFPC.net and go to the 3rd tab on the top. **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 each, 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 and one half business days in advance will be charged for the time reserved for you as your provider would be unable to assign the time to someone else.** If you have questions regarding this policy, discuss them with your doctor or therapist. **We do NOT call you to remind you of**

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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 a minor 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

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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 your 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 an 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: _____

Patient's Medical/ Surgical/ History: _____

Medications/dose/how taken: _____

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: _____

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: _____

Name: F: _____ L: _____ Relationship to Patient: _____

DOB: ____/____/____ Age: ____ Sex __Religion: _____ Occupation/School-grade: _____

Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____