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 typically 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 $250); 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 due at the time of service.

Telemedicine: Currently all appointments are conducted by Telemedicine Synchronous video or in some instances telephone. AAFPC clinicians use Zoom or Doxy, HIPPA compliant and confidential. No sessions are recorded. Please also read and complete Telemedicine consent ADDENDUM at the end of this document.

TELEPHONE CALLS: To communicate with your doctor or therapist please leave them a voice message 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)** situations. **Since your provider is on call essentially full time, we urge you to be considerate of their 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, side effect symptom/issue discussions, or appointment changes/cancellations. All of these matters should be handled by leaving a voice mail with your therapist**. You may send third party documents or test reports to office@aafpc.net with attention to your provider. The front office staff handles any emails received and distributes printed copies or forwards the message to your designated provider. 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. Most providers use e-Prescribe so be sure to leave your pharmacy phone number so they may find it in the e-Prescribe database.

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 TWO 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 your appointment.** If you are unable to cancel a session in time you switch to may have a telemedicine or phone appointment which is charged at the standard rate.

PAYMENTS: It is expected that you **pay for your services on arrival for your appointment** regardless of your insurance coverage. Telemedicine appointments are to be paid in advance of the appointment through our website: www.AAFPC.net. 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 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. Abrupt termination of many 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.

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: ____/_____/_____ Relationship to patient: _____

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

Street: _____; Apt: _____

City: _____; State: _____; Zip; _____

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

Email: _____@_____._____

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

Please circle Doctor/Therapist to be seen: **L. Ashley, K. Coffman, B. Gard, T. Iwanicki, S. Kirsch, L. Mette, A. Nitsche, 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: ____
____

COMMUNICATION WITH OTHER PROFESSIONALS:

May your therapist discuss your care with your referring professional? Yes ___ No ___
Referring Professional: _____________________________________ Telephone (_____) ______-__________
Address: ____ City: _____________ State: ____ Zip: ____________

TELEMEDICINE SERVICES ADDENDUM

Patient Information and Informed Consent for Telepsychiatry Service

Telepsychiatry is the delivery of psychiatric or psychotherapeutic services using synchronous interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

• A computer and a webcam with microphone to video conference using Zoom, Doxy or Skype software readily available to all computer users.

Potential benefits

• Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

• Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.

• The provider may not be able to provide medical treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure.

• Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

• Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.

• A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

Telemedicine: My Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

• I understand that the technology used by the provider is encrypted and is HIPPA compliant to prevent the unauthorized access to my private medical information.

• I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

• I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during the course of my care at any time.

• I understand that the all rules and regulations which apply to the practice of medicine in the state of Georgia also apply to telepsychiatry.

• I understand that the provider will not record any of our telepsychiatry sessions without my written consent.

• I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

Telemedicine: My Responsibilities

• I will not record any telepsychiatry sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.

• I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and agree to revert to a telephone voice session utilizing the indicated backup telephone number provided below should a video connection not function properly.

• I have read and understand that all clinic policies of the Atlanta Area Family Psychiatry Clinic apply to all telemedicine as well as all in-person visits

• I understand that I agree to be seen in person at least once a year to maintain therapeutic services and a provider/patient relationship. **This provision is waived until Covid-19 pandemic is resolved.**

• I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in the AAFPC's office in person prior to commencing telepsychiatry treatment. **This provision is waived until Covid-19 pandemic is resolved.**

• I consent to paying fees that are that same as an in office visits for the type and length of service provided by credit card phoned to AAFPC's secretary or a check mailed to AAFPC at the time of service.

• I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be and should I not be available for the appointment or cancel it less than two full business days in advance, it will be charged as a missed appointment for the time my practitioner has reserved for a scheduled appointment.

Telemedicine: Data and Signature page

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize the provider to use telemedicine in the course of my diagnosis and treatment.

Patient Name: First: _____ MI: ____ Last: _____

Date of Birth: _____/_____/_____

Address: _____, City: _____, State: _____ ZIP:_____

Patient email (for Zoom e-invitation): _____

Patient backup telephone contact: (_____) _____-_____

Alternate contact: (_____) _____-_____

Indicate the Telemedicine Provider who you will have your appointment with covered under this agreement/consent: _____

Signature: _____ Date: ___/____/_____

Patient ( ) or Guardian ( ) Relationship: _____

or

This consent may be digitally signed by typing in the blanks above and full name and date above and typing "I consent to these terms" on the line below:

Begin Typing Full Name Signature on the next line.

I accept these terms and conditions (initials): ___

Send Digitally Signed copy by email to Office@AAFPC.net (note this email address is only to be used to send documents to AAFPC), **we do not reply nor respond to messages sent by email**

or you may **FAX** them to **(770) 393-1885**