

Atlanta Area Family Psychiatry Clinic, P.C.

Child, Adolescent, Adult and Family Psychiatry & Psychotherapeutic Services

7000 Peachtree Dunwoody Road

Building 16, Suite 100

Atlanta, Georgia 30328-5754

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

BUSINESS POLICY ~ CONSENT for TREATMENT ~ PATIENT INFORMATION

Please read this information carefully and discuss any questions you may have with your doctor/therapist. This form MUST be completed and delivered to your provider prior to the date of your first appointment. E-sign it online in your portal or email it to: Office@AAFPC.net.

PORTAL: Sometime in 2023 you will have an online portal for you connection with your provider. Please be on the lookout for an email invitation to set up your portal and enter the required information.

CREDIT CARDS ON FILE: We require that a Visa, MC or Discover credit card be placed on file prior to any services. HSA cards require a backup credit card. You will be able to enter your credit card information in your portal when it becomes available. You may also call the front office during business hours to provide your credit card information. (770) 393-1880 ext. 0. If you are being seen in the office, it is expected that you pay for your services on arrival for your appointment. Telemedicine appointments must also be paid in advance of the appointment through our website: www.AAFPC.net. Any exceptions must be arranged through your therapist.

FEES:

NO SURPRISES ACT Federal regulation form: Our fees are listed below in compliance with Federal legislation. Please review this website for information on “No Surprises Act”:

<https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets>

Psychiatric Physician (M.D.)

New Patient 60 min \$405

53 to 68 min (scheduled as 60 min) \$360.

38-52 min appointment (scheduled as 45 min) \$300.

16-37 min appointment (scheduled as 25 min) \$210

Licensed Psychologist (Ph.D.)

New Patient, Initial session, 60 minutes \$250

45 min appointment, \$225

LCSW

New Patient, Initial session, 60 minutes \$210

45 min appointment, \$195

Extended sessions are billed at a somewhat higher rate. Prescriptions filled outside of an appointment are \$25 so notify your provider of your refill needs in your appointment. Expedited prescriptions are \$45.

Telemedicine: Many appointments are conducted by Telemedicine Synchronous video or in some instances telephone. AAFPC clinicians use Zoom or DoxyMe, both are HIPPA compliant and confidential.

No sessions are recorded.

TELEPHONE CALLS: To communicate with your doctor or therapist, please leave them a voice message through our voice-mail system, **(770) 393-1880 or a message on their portal depending on your provider.** 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, medication discussion/changes by phone or phone calls to 3rd parties (other providers, hospital, emergency department etc.) will be charged according to the time and level of service involved.**

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

URGENT RESPONSE: Your provider has a 24-hour, 7 day per week urgent response mailbox which may be used for **urgent (non-emergency)** situations, **(770)-393-1880 plus you provider's extension.** **Since your provider is on call essentially full time, we urge you to be considerate of their time.** In the event you are not able to reach your provider, you may contact the front office.

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 or your portal if your provider utilizes this part of their portal.** You may send **third party documents or test reports** to office@aafpc.net with attention to your provide or upload them on your portal. 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 (or more for USPS) for receipt of mailed Rx's.** We will make every effort to accommodate urgent (same day) Rx refill requests (\$45/per day regardless of number of Rx's) if the request is received by noon of that day. **Prescriptions filled outside of an appointment are \$25.** 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. **We do not respond to direct pharmacy refill requests as they are often inaccurate or out of date.**

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 or your portal once active.** **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 may switch to have a telemedicine or phone appointment which is charged at the standard rate.

INSURANCE: **We do not file insurance claims nor do our providers participate in any insurance plans,** however, many services we provide are covered by insurance as "**out of network benefits.**" Some insurance companies fraudulently list us as in-network providers, but we have never signed with any companies. 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 or mail 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.

MEDICARE, TRI-CARE and MEDICAID OPT OUT: Our providers have “opted out” of these governmental plans therefore you agree that if you have coverage under any of these plans, you will not file for reimbursement with them as this is in conflict with governmental regulations for “opted-out” providers.

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. Balances over 30 days due are deemed 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. If 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 guarantor of payment for a minor patient, you accept responsibility for all charges incurred providing care to this patient regardless of patient reaching age of majority unless you rescinded guarantor status in writing to Atlanta Area Family Psychiatry Clinic, P.C. The Adult patient will then need to fill out and sign a consent for treatment once they reach the age of 18 years.

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. A provider may also decide to discontinue care for noncompliance to treatment plan or repeated failing to make appointments. If you have not been seen on over one year, you will be considered a NEW 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 your 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 or over the counter substances added or changed by you or other medical providers outside AAFPC.

Please circle Doctor/Therapist to be seen: **L. Ashley** **B. Gard** **T. Iwanicki** **S. Kirsch**
L. Mette **A. Nitsche** **L. Perez** **M. Peters** **E. Slayden** **R. Slayden** **L. Waugh**

Patient Name: F: _____ L: _____ DOB: ___/___/___ Age: ___

GENDER: M_ F_ Other ____, 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: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _____

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

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

DOB: ___/___/___ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _____

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

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

DOB: ___/___/___ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _____

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

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

DOB: ___/___/___ Age: _____ GENDER: M_ F_ Other ____, 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, Face Time 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 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.
- 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.**
- I consent to paying fees that are that same as an in-office visits for the type and length of service provided as described in the “New Patient Policy.”
- **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.**

SIGNATURE PAGE

I hereby give my informed consent for my or my child’s care and also authorize my provider to use of telemedicine in the course of my diagnosis and treatment if necessary.

Please sign acknowledging that you consent to all of the above 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 if different from patient:

First: _____ **MI:** _____ **Last:** _____

SSN: _____ - _____ - _____ **DOB:** ____/____/____ **Relationship to patient:** _____

Patient's name: F: _____ **L:** _____ **DOB** __/__/__

Street: _____; **Apt:** _____

City: _____; **State:** _____; **Zip:** _____

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

Email: _____@_____._____

Responsible Party Signature: _____ **Date:** __/__/__

Relationship to patient: _____