MACON PSYCHIATRY

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Diplomat of Child and Adolescent Psychiatry
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Patient Information Form

This form provides your doctor with more information about you, your reasons for seeking treatment, and other relevant details prior to your first visit.

At your first appointment you will need to bring: a current list of medications and your most recent lab work if applicable.

Initial _____

Patient Full Name: _____ DOB: _____
☐ Male ☐Female SSN: _____

Home Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Would you like us to send information about your appointments though email? ☐Yes ☐ No

How do you prefer Macon Psychiatry to contact you? ☐ Phone ☐ Text ☐ Email

Employer Name: _____ Occupation: _____
If other than yourself:
Person Responsible for Account: _____Date of Birth: _____
Best Contact Number: _____SSN: _____

Ethnicity: ☐Caucasian ☐ African-American ☐ Asian☐ Hispanic ☐Other _____

Relationship Status: ☐Single ☐Married _____yrs ☐Serious relationship _____yrs ☐Divorced _____yrs

How did you first find out about us?_____

Is there anyone we can thank for referring you? _____

Emergency Care Information
Personal Physician Name: _____Phone: _____
May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?
☐ No ☐ Yes If yes, please complete/sign "Consent" form in attached paperwork.

Family and/or friends to be contacted in an emergency:
Name: _____Relationship_____Phone:_____
Name: _____Relationship_____Phone: _____

Current Concerns
Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:
_____
_____
_____

Previous or Current Psychiatrist/Therapist
Name of Clinician: _____ Phone Number _____Treatment Date_____
Name of Clinician: _____ Phone Number _____Treatment Date_____

Medications (Please provide a list of your current medications to the front desk to scan into your file)
☐ I am not on any current medications

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors and Macon Psychiatry at my next appointment.

_____ _____
Signature of patient or legal/representative of patient Relationship if other than patient

_____ _____
Patient's Name (PRINT) Date

Treatment Information and Authorizations

This form provides you with information about treatments that may be offered to you, including psychotherapy and/or medication(s). Please read the information carefully, and sign the authorization prior to your first visit at Macon Psychiatry.

Initial _____

TREATMENT CONSENT FORM

PSYCHOTHERAPY

Psychotherapy may have benefits such as significant reduction in distress, improved social relationships, resolution of specific problems, and clearer understanding of yourself, your values, and your goals. However, there are no guarantees about what will happen in therapy. For therapy to be most successful, you will have to be able to talk openly and honestly, address any difficulties that arise, and put forth active effort outside our sessions.
Psychotherapy may also require revealing unpleasant aspects of your history and current life. Therefore, in the initial stages of treatment, psychotherapy may lead to uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness and could impact your relationship with others. While unpleasant experiences are usually temporary, please let us know if they occur.

By the end of your initial evaluation, we will offer you some initial impressions and an initial treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to offer referrals for you to secure an appropriate consultation with another mental health professional.

Initial _____

MEDICATIONS

Medications are often used as adjuncts to psychotherapy. Sometimes, you will be seeing someone else for therapy, and we will be responsible for your medication management. If this is the case, we will coordinate your medical care and medication goals with your therapist. If we are doing both your medication management and psychotherapy, we will work together to find the optimal combination of medication (if warranted) and therapy that help to fulfill your personal goals.

If a medication is indicated, we will discuss with you the nature of your illness, the reason for the medication, the likelihood of improving with and without medication. We will also explain any reasonable alternative treatment other than medications which have not been tried and an explanation why they should not be tried first. Further, you will understand the type(s) of medication being recommended; dosage and frequency of administration including a discussion of the initial dose, the maintenance dose and the dose range; probable side effect known commonly to occur and any side effects likely to occur in particular cases, as determined by your medical and psychiatric history or known medical conditions; and any possible long-term effects which may occur after taking the medication for long periods or terminating the medication, including tardive dyskinesia or withdrawal. Finally, we will discuss the effect of sudden withdrawal of the drug against medical advice. As many psychiatric conditions have an underlying biological basis, medications can be an important component of treating certain illnesses. It is our belief that a bio-psycho-social model to treatment --incorporating biological aspects, psychological factors and social components -- provides most patients the best chances of improving. We will look at all of these areas through the course of our treatment and decide which interventions are right for you.

Initial _____

SESSIONS

Our normal practice is to conduct a thorough evaluation in the initial interview. This comprehensive assessment is necessary whether we will provide you with therapy, medication management, or both, as it will allow us to better understand your history, your symptoms, and your reasons for seeking treatment. Before the end of the first visit, your clinician will determine whether or not you will benefit from further evaluation or begin treatment.

In some cases, an additional visit may be necessary to complete the initial evaluation (e.g. for someone with an extensive psychiatric history or complicated presentation) as extra time may be needed to gather information from you, speak to your family or loved ones, review past medical records or order any necessary lab work. If this is the case, your clinician will ask to schedule additional time (30-60 minutes) with you at a future date in order to complete your initial evaluation. During this time, as well as in the next 1 to 2 sessions, we can both decide whether we are the best practice to provide the services that you need.

If psychotherapy is initiated, we will usually schedule one 50/60minute session per week at a mutually agreed time. We may agree to vary session length and frequency.

Please note, that if you transfer your care for any reason from one provider to another, or are referred from one clinician in our group to another for any reason (including medication evaluations) you will be required to complete at least one 60-minute consultation appointment, in order for the new clinician to adequately complete transfer of care, and to conduct a thorough evaluation to initiate or continue treatment.

Initial _____

FEES:

We try to schedule our appointments with the least estimated timeframe, however, there are times we may require more or less time than we originally estimated. In the case that an evaluation goes longer than the estimated time we bill in 15-minute increments as listed in the fee schedule.

For adult patients over the age of 18

- $650 for a 90-minute initial consultation, regardless of whether it is for medications, psychotherapy or both
- $450 for 45-50-minute psychotherapy sessions, with or without medications
- $150-$250 for 15-30-minute medication-only, follow-up visits

For patients under the age of 18

- $675 Initial assessment is two 45-minute appointments
  First Parent/Guardians only – for a 45-minute initial consultation
  Second with Child – for a 45-minute consultation. Parents and legal guardians are requested to be present at the initial meeting, to be able to provide consent for treatment as well as historical and collateral information for 50-60-minute follow-up psychotherapy sessions, with or without medications
- $450 for 45-50-minute psychotherapy sessions, with or without medications
- $150-$250 for 15-30-minute medication-only, follow-up visits

The initial evaluation for a child or adolescent, two 45-minute evaluations are mandatory, to allow time for the psychiatrist to meet with the patient, as well as the family members, to formulate a comprehensive diagnosis and treatment plan, and to discuss this with the child/adolescent as well as the family. If it is a complicated presentation, or there are multiple family members, this process of obtaining accurate history and collateral and formulating a comprehensive biopsychosocial treatment plan for a child or adolescent, which can be shared with the child/adolescent and their family, may span several appointments. Our office also offers 90-minute follow-up appointments if he and/or the child/adolescent/family believe that longer follow up visits are important for more in-depth treatment and would facilitate greater progress.

Initial _____

TESTING FEES

PSYCHOLOGICAL, PSYCHODIAGNOSTIC, VOCATIONAL, COGNITIVE, or OTHER TESTING FEES:

A testing proposal will be generated after an initial consultation meeting with the psychiatrist, including the type(s) of testing proposed, number of hours involved in testing, observation, and report writing, estimate of costs of in office or outside of office testing and/or observation, plus one-time testing materials fee. This proposal must be signed by patient/payor prior to initiating testing. Payment for testing is due as follows: 1/2 prior to starting testing, 1/2 at the conclusion of testing, paid in full prior to writing the report.

- $450 per hour for testing and report writing in office, plus $150 one-time supply fee for testing materials
- $450 per hour for observation/IEP (Individualized Education Program) or 504 advocacy outside the office (at home, school or office); plus $150 one-time supply fee for testing materials (if not already paid above)
- $650 per hour for legal testing, observation, report writing, testimony, deposition; plus $150 one-time supply fee for testing materials if not already paid above.

**Please note: A hard copy of the testing report will be provided to the patient (parents if minor)/lawyer/institute only after the entire report has been:

- paid for in full
- and reviewed in person with the patient (and/or parents, if minor) by the testing psychiatrist (and referring clinician if necessary)

Initial _____

LEGAL TESTIMONY

It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. Please understand legal testimony can often be damaging to the relationship between a patient and his/her clinician. Because of this, we require that the lawyer retain the psychiatrist for the agreed fee of $650.00. Then upon signing an agreement we will schedule the initial evaluation and forensic consents. The fees for each case will vary and will follow the fees in the appropriate sections of this consent. You will go through a series of evaluations/testing and reports pertaining to the case. Then after the case is closed, we can continue care as before. If for any reason, any of our clinicians is deposed or subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees, which are $2600 per half day (4hours or less), and $4800 for a full day (4-8 hours). Which are to be paid prior to court date.

Initial _____

OTHER PROFESSIONAL SERVICES

If you request copies of your psychiatric medical records, you will be responsible for a $0.25/per page charge for all pages of your chart, an administrative fee for time spent copying or sending records, as well as any costs incurred from mailing records certified. These fees will need to be collected prior to the release of records, and only after a signed consent for release form has been completed by you on Macon Psychiatry's Consent for Release form. Further, psychiatric records are among the most highly protected records in medicine, and Macon Psychiatry's policy is to release these records only upon signed consent for release by our patients, and then only to mental health providers who will be continuing your care, or to whom you are transitioning your treatment.

Initial _____

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to pay for it unless you provide at least 48 business hours advance notice of cancellation. This includes initial evaluations, follow up appointments, and group therapy sessions. Business hours are considered the weekdays between Monday and Friday, during the hours of 8 am and 5 pm, and do not include evenings, weekends or holidays when the office is closed. This means that if you have an appointment on Monday January 7th at 4 pm, you must cancel by 4 pm Thursday January 3rd to avoid being charged. If you do not provide at least 48 business hours' notice, or fail to show for a scheduled appointment, you will be responsible for the full cost of the session and there will be no refund. This includes group sessions. Please note, insurance companies will often not reimburse for missed sessions or sessions that are cancelled late.

Initial _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of scheduling each session. Credit cards, personal checks and cash are accepted. **Please note: there is a $35 administrative fee assessed for any returned check and for each incident of a declined credit card. We strongly encourage you to keep an accurate and active credit card on file to charge for your sessions. If your account has payment overdue for over 60 days, we have the option of using legal means to secure payment, including collection agencies or small claims court. In most cases, the only information we would be providing would be your name, nature of services provided, and amount due.

Initial _____

INSURANCE REIMBURSEMENT

We do not take insurance, and are considered an "out of network provider" for insurance plans. If you have a health benefits policy, especially a PPO, it will usually provide some mental health coverage. However, you, not your insurance company, are responsible for full payment of the session fees. We will not bill your insurance directly. If you plan to use your insurance benefits, we will provide you with a standard receipt and form that can be submitted to your insurance company.

Many PPO plans do provide some reimbursement for mental health provided by an out of network provider, so you may get a substantial portion of our fees back from your insurance company, depending on your specific plan. We recommend you contact your insurance provider to inquire about your out-of-network benefits if insurance reimbursement is an important issue. Please be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plan or summary, or in rare cases, a copy of the entire record. We are required to submit this information on your behalf if you choose to obtain insurance reimbursement.

Initial _____

SUMMARY OF MEDICARE ACCEPTANCE POLICY

Macon Psychiatry does not participate in Medicare. By law, Medicare-eligible patients are required to enter into a private contract with Macon Psychiatry. and we deliver medical care on a fee-for-service basis, which is NOT reimbursable by Medicare. By accepting the treatment contract with Macon Psychiatry, you agree that you shall not submit a claim or ask Macon Psychiatry to submit a claim for payment under Medicare for services rendered, even if such items and services would otherwise be covered by Medicare.

This means that you agree not to bill Medicare or ask Macon Psychiatry, Inc. to bill Medicare, for services rendered by our personnel. Please note, the private contract is with Macon Psychiatry and applies only to our practitioners. You are not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other clinicians or healthcare practitioners. This means that Medicare-covered services and payments are still available to you from other clinicians or practitioners who have not opted out of Medicare, and therefore you may, if you so choose, use the services of those clinicians or practitioners even when you enter into this private contract with Macon Psychiatry.

Initial _____

CONTACTING US

Our staff is available to help you during normal business hours at (478)733-2690. If our staff is busy when you call, or it is after hours, our voicemail at (478)733-2690 will answer so you can leave a message. We monitor our voicemail frequently and will return your call as soon as we can. Please be aware that all correspondence (voicemails and emails) will be transcribed by staff as part of your permanent record. We will make every effort to return your call on the same day you make it with the exception of after hours, weekends and holidays (please let us know if the call is urgent). When you call, please leave both times and phone numbers where you can best be reached. If you consider the call an emergency, and it is outside business hours, there are instructions on each clinician's voicemail of how to page us via our cell. If it is a true medical emergency, you can call your family clinician, the Emergency Room at the nearest hospital, or 911 and describe your circumstances. You can also go to any Emergency Room at any hospital.

If we will be unavailable for an extended period of time, we will provide you with the name of a trusted colleague whom you can contact if necessary. With respect to e-mail, please be aware that while all of our clinicians are available via email, cell phone and text, none of these are completely confidential means of communication. Furthermore, we cannot ensure that these types of electronic messages will be received or responded to in a timely fashion as we check them on an irregular basis.

E-mail and text are not an appropriate way to communicate confidential information or emergency issues. Furthermore, please be aware that voicemails, emails and texts may be shared with administrative staff to transcribe or print out to incorporate into your permanent record.

Initial _____

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. You are entitled to review a copy of the records; unless we believe seeing them would be emotionally damaging, in which case, we will be happy to provide them to an appropriate mental health professional of your choice. Because these are professional records, they can be misinterpreted or upsetting, so we recommend that we review them together so that we can discuss what they contain. We can also prepare an appropriate summary for review. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.

Initial _____

CONFIDENTIALITY

Confidentiality is the cornerstone of mental health treatment and is protected by the law. We can only release information about our work to others with your written permission. Some basic information about diagnosis and treatment may be required as a condition of your insurance coverage. Exceptions to confidentiality where disclosure is required by law:

- if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization
- if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection
- if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency
- if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs

These situations have rarely arisen in our clinical practice, but should such situation occur, we will make every effort to fully discuss it with you before taking any action. We may occasionally find it helpful to consult with other professionals. In these circumstances, we will make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential.

Initial _____

PRACTICE STATUS

Macon Psychiatry is a practice with a single provider, who are responsible for the care and treatment of their own patients. Please also note that while the administrative staff has access to patient's chart, for contact, prescription, transcription, documentation and administrative purposes, they are not privileged to the clinical content therein. Our professional records are separately maintained and will not be shared with anyone outside of Macon Psychiatry, or even within Macon Psychiatry, who is not a part of your treatment team, without your specific, written permission.

Initial _____

Also, we have a network of colleagues (primary care clinicians, other therapists, etc) that we often refer patients to as part of a treatment team approach. If a referral to another professional is indicated, we will work with them to collaborate and coordinate your care, and will request your permission to discuss your case with them. While we do our best to select extremely high-quality professionals with standards of care similar to our own to which to refer, we take no responsibility for the treatment they provide. It is up to you to determine if a professional we have referred you to is right for you, and the referred professional alone is responsible for the care they provide.

Initial _____

NOTICE TO PATIENTS

Physicians and child, adolescent and adult psychiatrists (MDs) are licensed and regulated by the Medical Board of Georgia. For more information, call (404)656-3913, or go to https://medicalboard.georgia.gov

TREATMENT CONSENT FORM

Your signature below indicates that you have read the entire Macon Psychiatry Treatment Consent Form, which contains information on clinical services, sessions, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, and practice status, and you agree to abide by its terms throughout our professional relationship.

_____	_____
Signature of patient or legal/representative of patient	Relationship if other than patient
_____	_____
Patient's Name (PRINT)	Date

HIPAA Patient Privacy Notification

This serves as your notification of your rights to privacy, under the Health Care Information Portability and Accountability Act. Please print out this notification and keep it for your own records.

NOTICE OF PRIVACY PRACTICES

Privacy Officer: Elaine Price
Effective Date: May 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, Georgia law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Georgia law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. Fundraising. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION
Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. YOUR HEALTH INFORMATION RIGHTS
1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and Georgia law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Southeast Region
Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD :(800) 537-7697
Email: ocrmail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

RECEIPT OF PRIVACY NOTIFICATION FORM

Please sign this form to indicate you have received a copy of the HIPAA Patient Privacy Notification and bring it to the initial visit for inclusion in your chart. Privacy Officer: Elaine Price (478)733-2690

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____ _____

Patient's Name (PRINT) Date of Birth

_____

Signature of patient or legal/representative of patient

_____

Relationship if other than patient

_____

Date

Consent for Release of Information

Please fill out this form if you have another doctor or therapist, or friend or family member, whom you would like your doctor to contact to obtain or give information about your diagnosis, treatment, prognosis, etc. You can specify to whom the information should be released, and what type of information can be shared. At Macon Psychiatry, we believe in close cross-collaboration between treating clinicians (i.e., having your psychiatrist and psychologist talk about your care) and in coordination of primary care and psychiatry. Having a Consent for Release of Information form allows your psychiatrist or therapist to provide you the best integrated care possible.

Initial _____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION:
I hereby authorize:

_____ (Physician/Healthcare Facility/Individual)

To release information on:

_____(Patient's Name)_____(Patient's DOB)
regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:

_____
Name

_____
Address

_____
City State Zip Code

The medical information/records will be used for the following purpose:
_____

This authorization is:
[ ] Unlimited (all records, including Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information:
_____
_____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse: _____ (initial)
Psychiatric/Mental Health: _____(initial)
Tests for Antibodies to HIV: _____(initial)
HIV Diagnosis/Treatment: _____(initial)
Genetic Information: _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until:_____Date.

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/representative of patient Relationship if other than patient

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness Name Witness Signature

Insurance Information

At Macon Psychiatry, we do not take any type of insurance and our doctors are considered out-of-network providers for all insurance panels. We will not bill your insurance directly for any services. However, we will provide you with a receipt for any services provided so that you may bill your own insurance for whatever reimbursement they will provide. Although we will not be billing your insurance directly, some patients do go through their insurance for medications, which often requires additional authorization from our office. Having your insurance information on file will make it easier for our office to expedite any of these requests

Initial _____

INSURANCE INFORMATION

Please provide the front office with a copy of your insurance card

(Please Note: "Policy Holder" refers to the name of the person who holds the insurance plan)

Patient Name: _____
Patient's relationship to the policy holder: ☐Self ☐Spouse ☐Dependent

Policy Holder's

Full Name: _____☐Male ☐Female
Address: _____
_____
Primary Phone: (_____) _____
Work Phone: (_____) _____
Date of Birth: _____/_____/_____
SS#: _____

Name of Insurance Company: _____
Employer that the Insurance is through: _____
Insurance Phone Number: (_____) _____
Insurance Address: _____
_____
Policy Holder/Member/Subscriber ID #: _____
Group #: _____

Credit Card Authorization

When you make an appointment at Macon Psychiatry, we will block that time out for you in your clinician's schedule, and in return request that you fill out a credit card authorization form. This card will be used per our office policy and per your prior authorization

Initial _____

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, _____ , am authorizing Macon Psychiatry, to charge my credit card for any services rendered as agreed to in the Treatment Consent Form. I also authorize MP to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 48 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize Macon Psychiatry to charge my credit card for the full amount due. I will not dispute for sessions I have received, or that I have not cancelled less than 48 business hours in advance.

I further authorize Macon Psychiatry to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $35 fee for any declined credit card charge.

Card Type: ☐Visa ☐MasterCard ☐Discover ☐Amex

Card #: _____

Expiration Date: _____/_____ Security Code: _____

Name as Printed on Card: _____

Relationship to patient: _____

Billing Address: _____
Street City State Zip

Signature:_____ Date:_____
(Financially Responsible Party)

*Cancellations must be made at least 48 hours in advance or fee must be paid in full and I am aware there is a $25.00 fee for declined credit cards.

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: you authorize payment for treatment using card on file, no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.

Telehealth Consent Form

In the event that our patients are out of town, or unable to come to their appointments, our clinicians can conduct phone sessions with them, so the treatment and support can continue without interruption. This form gives your consent to speak by phone with our clinicians

Initial _____

TELEHEALTH CONSENT FORM

I hereby authorize Macon Psychiatry, Dr Deepti Bhasin to use telehealth (telephone, video, email, text, and fax) in the course of my diagnosis and treatment. I understand that "telehealth" allows my psychiatrist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment.
I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

I understand that my physician reserves the right to advise and refuse that I not receive my care through telehealth.

I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse. I understand that I can expect benefits from telemedicine, but that no results can be guaranteed or assured. [Where applicable: Telemedicine provides me with access to medical care that otherwise would not have been available.]

I have read and understand the information provided above. I have the right to discuss any and all of this information with Macon Psychiatry and to have any questions I may have regarding my treatment answered to my satisfaction.

Other risks include but are not limited to: Although all text messages, voice mail and email are kept confidential, choosing this method may lead to your information not being protected. If you choose to communicate with your psychiatrist in this manner, you must understand the risk and consent to using the following email, cell and text below.

Recording of sessions is never allowable and permission must be granted before authorizing the recording of a session. It is not permitted ever to record any session without the expressed written permission from the participants and the licensed clinician.

SKYPE Video
Skype encryption technology utilizes the "AES encryption protocol", it meets the Federal Information Processing Standards (FIPS) for electronic transmission under HIPAA.
However please note that: One major issue with Skype is the fact that they have been unwilling to declare that they are HIPAA compliant or sign a BAA (Business Associate Agreement) which is a necessary requirement for HIPAA compliance. This means that Skype does not disclose security breaches or findings from security audits. Therefore, if you use Skype, you do so knowing that you are using a vendor who has declared that they won't provide providers with a "Business Associate Agreement," as mandated by HIPAA.

Skype ☐Yes _____ (Initial)
☐ No_____(Initial)

Facetime ☐Yes _____ (Initial)
☐ No_____(Initial)

I consent to using email communication using the following email: _____

I consent to using text messages using the following cell number:_____

_____ _____
Signature of patient or legal/representative of patient Relationship if other than patient

_____ _____
Patient's Name (PRINT) Date

Consent for Services and Financial Agreement

CONSENT TO SERVICES AND FINANCIAL AGREEMENT

Name of Patient:_____ DOB: _____

Name of Parent/Guardian :_____

In applying for services with Macon Psychiatry, I understand that I may be administered diagnostic and treatment procedures as may be determined by Macon Psychiatry and as approved by myself, the parent or guardian. Medical and other records may be maintained by Macon Psychiatry for assessment and treatment. These records are confidential and are for the use of Macon Psychiatry only.

I have read and understand the statements regarding HIPPA and patient's rights.

I understand that medical doctors are licensed and regulated by the Medical Board of Georgia

Macon Psychiatry will attempt to safeguard the patients in his care but he will not be responsible for any accidental injuries and assumes no liability for injuries occurring without any fault or negligence.

Macon Psychiatry accepts a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of clinician, he or she is not able to benefit, withdrawal will be recommended and other plans discussed.

I understand that while Macon Psychiatry will provide information required to obtain insurance company reimbursement, they will not bill insurance companies directly, nor will they negotiate a settlement on disputed charges. I understand that I am fully and personally responsible for payment of Macon Psychiatry's charges at time of services rendered. Failure to comply with this policy may result in postponement or cancellation of future visits. Furthermore, if the amount due is not paid in full, I agree to bear all collection costs, court costs and legal fees.

I understand that because of the highly specialized nature of his practice, Macon Psychiatry does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, workers compensation cases or victims witness cases. Neither Macon Psychiatry nor any clinician is a Medicare provider.

I understand that Macon Psychiatry requests payment at time of visit by cash/check/credit card.

I understand that if for any reason an appointment needs to be changed or cancelled by the patient, 48 hours notification by telephone or email will be given to Macon Psychiatry. Failure to properly notify the physician will result in charges at the usual rate for that appointment. Exceptions will be made for legitimate emergencies as per physician discretion. I am in complete agreement that remembering upcoming appointments as set forth by Macon Psychiatry is my sole responsibility, and that MP is not obligated to send reminder emails/phone calls prior to upcoming appointments as reminders. If you miss a scheduled appointment, you will be charged the full fee for the scheduled visit.

I understand that the doctor may charge (at his discretion, which will be defined depending on situation) for telephone consultations and for all other uses of his time on my behalf.

I have read and understand the above-mentioned policies and guidelines and will abide by all of these policies for services.

_____ _____

Signature of patient or legal/representative of patient | Relationship if other than patient

_____ _____

Patient's Name (PRINT) | Date