

Psychiatric Associates of Atlanta, LLC
Twelve Piedmont Center, Suite 410
3495 Piedmont Road, NE
Atlanta, GA 30305
404-495-5900
404-495-5901 (fax)

PATIENT INFORMATION:

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Date of Birth: ____________ Age: _____ Sex: MALE / FEMALE

Social Security #: _____ - _____ - _____

Which doctor are you seeing today? Dr. Lipsig Dr. Norman

Who referred you to this practice? _____

Is it okay to leave a message for you from us (circle one)? YES / NO

If so, what telephone number do you prefer us to use? (_____) _____ - _____

PERSONAL INFORMATION:

Patient's Employer: _____ Phone: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

Person responsible for charges incurred: _____

Relationship to Patient: _____ Phone: _____

If person responsible for bill other than patient, please complete Guarantor Form.

If Patient is a Minor or Student Dependent:

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

INSURANCE INFORMATION (Complete only if you have Medicare):

Medicare Policy #: _____

Drs. Lipsig and Norman are non-participating providers for Medicare. You will be responsible for fees incurred. Psychiatric Associates of Atlanta will file the Medicare insurance for you and you will be reimbursed for a portion of your bill by Medicare in about 30-60 days after your visit. Please discuss this policy with your physician prior to treatment if you have any questions.

Do you have Medicaid (circle one)? YES / NO

Currently, the physicians in this group are not Medicaid providers and cannot treat Medicaid patients. Please inform your physician prior to treatment if you have Medicaid. We can try to provide you with a name of a Medicaid provider.

MEDICAL INFORMATION:

Allergies (Circle one)? YES NO List all: _____

Medications taking at present: _____

Primary Physician: _____ Phone: _____

Have you recently had any thoughts of hurting yourself and/or anyone else? YES / NO

RECORD RELEASE AUTHORIZATION:

I hereby authorize Psychiatric Associates of Atlanta to furnish information to insurance carriers concerning this illness/accident.

Patient's signature: _____ Date: _____

CONSENT FOR TREATMENT:

I hereby agree to be treated by physicians and/or mental health professionals associated with Psychiatric Associates of Atlanta, LLC. I agree that I am personally responsible for ensuring that all charges for services rendered are paid. I authorize Psychiatric Associates of Atlanta to provide information concerning my treatment to any physician or therapist who referred me to Psychiatric Associates of Atlanta.

Patient's signature (Parent or Guardian, if minor): _____

Date: _____

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

____ VISA ____ MasterCard ____ American Express ____ Discover

Name as it appears on card

Billing Zip Code

____ - ____ - ____ - ____
Credit / Debit Card Number

____ / ____
Exp. Date

I/we authorize Psychiatric Associates of Atlanta, LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as "Associates of Atlanta" since the word "Psychiatric" has been removed. I will notify Psychiatric Associates of Atlanta in writing if I no longer want my credit / debit card billed.

Signature of cardholder

Date

CREDIT CARD PAYMENT for LATE CANCELLATION OR NO-SHOW

I authorize Psychiatric Associates of Atlanta to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature of cardholder

Date

GUARANTOR INFORMATION (complete only if the patient is NOT paying for the bill):

Name of party responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Date of Birth: ____ \ ____ \ ____ SS#: _____

Guarantor-Financial Responsibility Agreement

I, the undersigned, that regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

Signature: _____ Date: ____ / ____ / ____

PSYCHIATRIC ASSOCIATES OF ATLANTA POLICIES

OFFICE HOURS:

Office hours are Monday through Friday by appointment only. All first appointments are considered a consultation only. Your doctor will let you know if he is in the position to offer treatment services beyond the first appointment.

EMERGENCIES:

Call our answering service at 770-928-5228. Ask to have the on-call physician paged. Your physician or another physician associated with our practice will return your call. The on-call physician will return your call as soon as possible. If you cannot wait, please call 911.

PAYMENT POLICY:

All new patients will need to pay the initial evaluation fee in full at the time services are rendered. If the patient continues to be followed at Psychiatric Associates of Atlanta, then payment for services can be discussed with your individual physician. Generally, fees are due at the time of service unless other arrangements have been made. Psychiatric Associates of Atlanta does not currently contract with any insurance carriers. Please check with your insurance company as to whether or not you would qualify for out-of-network benefits. If so, your physician can fill out the necessary forms and your insurance company will reimburse you directly. We accept credit and debit cards as a convenience (see above).

Finally, all charges that are past due over 90 days may be sent to our collection agency unless arrangements have been made with your physician. We encourage patients to be aware of the charges that are being incurred.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients will be charged the full session rate when cancellations occur unless notice is given at least one business day in advance. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.

ELECTRONIC MAIL (EMAIL) POLICY

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature. Additionally, your doctor will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature. Your doctor will make an effort to check email regularly; however, call our office if you have not received a reply within 72 hours.

TELEPHONE POLICY:

To provide quality care to our patients, our physicians like to personally return calls to their patients. Routine phone calls made between the hours of 8:30 a.m. and 3:00 p.m. on weekdays will be returned within twenty-four hours. Routine calls received after 3:00 p.m. or on weekends may be returned the following business day. If it is an emergency, please convey this when making your call. Please be advised that this is for brief phone calls only (for example, a question concerning current medication).

For more extensive phone calls, please schedule a phone appointment with your physician. There will be a routine charge for these phone calls based on the time spent per call. Please note that most insurance companies will not reimburse for phone consultation fees.

TELEPHONE REFILL POLICY:

Medication refills may be requested between 8:30 a.m. and 3:00 p.m. weekdays and will be called into the pharmacy on the same business day the request is made. Requests after 3:00 p.m. will be recorded on the following business day. When requesting a refill, please provide:

Your name, your date of birth, name of medication requesting, dosage, and pharmacy telephone number.

Prescriptions may only be called in for patients who are current patients and who maintain their regularly scheduled appointments. For your safety, medication refills will not be called in over the weekend except in emergencies. There may be a charge for telephone refills requested after business hours unless prior arrangements have been made in advance with your physician.

TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly.

ACCEPTANCE OF POLICIES:

Psychiatric Associates of Atlanta is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly we require agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing. I have read the policies, understand, and agree with them.

Patient's signature: _____

Guardian if a Minor: _____

Date: _____

NOTICE OF HEALTH INFORMATION PRACTICES

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

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the treatment. In that way the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy your health record, amend your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For additional information about our health information practices or to report a problem, you may contact Drs. Lipsig or Norman at 404-495-5900. A full copy of this notice is available from Drs. Lipsig or Norman or at www.atlantapsychiatry.com. If you believe your privacy rights have been violated, you can file a complaint with Drs. Lipsig or Norman or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

My signature below indicated that I have read the notice of privacy practices.

Signature: _____ Date: _____