Date:_____________________________ Referred by:_____________________________

PATIENT INFORMATION - Please fill out completely.

Last Name:______________________ First Name:______________________M.I.__________

Street Address____

City:____________________ State:__________ Zip:____________Gender (Circle): Female/ Male

Home Phone:______________Office Phone:______________ Cell:____________________

Email:______________________Date of Birth:_______________ SS#:______________

Marital Status: (circle) Single / Married / Divorced / Widowed / Separated / Partnered / Other ____________________

Employer/School Name and phone number:____

Spouse's Name and daytime phone number:____

If patient is in a group or personal care home please provide the **NAME OF FACILITY/CONTACT PERSON/PHONE NUMBER** below:

____

Responsible Party: Provide info on who is responsible for paying for the service (if different from patient)

Name:____ SS#:________________

Address:____ Phone:____________

Relationship to Patient?____

<u>Emergency Contact:</u> (Name/number/relation) ____________________________________

****Insurance <u>Policy Holder's Information</u>: (If you are the policy holder please leave blank)**

Name of Policy Holder:______________________________ ID#: ______________________

Policy Holder's date of birth:______________ SS#:________________ Relationship to Pt:________

Name of Insurance Co:____

Phone number and address of policy holder:_______________________________________

Employer of Insured:______________________________ Group #:____________________

Confidentiality: Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, Eastern Atlanta Behavioral Health (EABH) will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.

PATIENT'S BILL OF RIGHTS/GENERAL POLICIES AND PROCEDURES

We are happy to provide you with this list of your rights as defined by the American Medical Association:

*Non Discrimination
*Information about your diagnosis prognosis and treatment plan
*Voluntary consent to treatment
*Approximate overall cost and billing information
*Right to seek another opinion
*Continuing healthcare after discharge from outpatient or inpatient care
*Privacy
*Third person present during treatment
*Identification of person providing service
*Active participation in decision making about your health status
*Knowledge of the need for continuation of care
*Knowledge of human experimentation
*Expected conduct in the outpatient setting
*Safety

Financial Policy

- Co-payments, co-insurance, deductibles and/or pre-service deposits are due at the time of service. Due to legal considerations this policy must be applied uniformly.
- Insurance requires pre-authorization. Payment in full is expected without proof of authorization. The appropriate payment is required at each visit, if the patient is a minor; payment is still required regardless of the relationship of the adult to the minor. In the case of children of divorced parents, payment is due at the time of service regardless of the terms of the divorce decree.
- EABH will bill the insurance company on behalf of the patient.
- Benefits will be assigned.
- The patient authorizes EABH to release any necessary information to process the insurance claims.
- Charges not paid by your insurance company within 180 days will become the patient's and/or legal guardian responsibility.

General Clinical/Administrative charges (the following may apply and are expected upon registration prior to services being delivered):		
	Charge	Per
Missed appointment without notification by noon of the prior business day. 3 Missed appointments will result in discharge from the practice.	$55.00	Appointment Missed
Routine paperwork (e.g. requests for records)	$50.00	Filled Request
Extensive paperwork	$100.00	Filled Request
Returned check	$30.00	Return
Counselor/Therapy rate	$150.00	Session
MD rate - follow-up/medication management	$100.00	Session
MD rate - initial intake evaluation with or without medication management	$300.00	Session
Alternate Arrangement: (Staff to specify, initial and date)		

APPOINTMENT POLICY Consultation with staff is by appointment only. Call us at 706-357-5467 to schedule an appointment. Each time that you call the clinic, our staff may confirm that our records have your correct daytime and evening telephone numbers as well as your correct mailing address. This will allow our clinic staff to contact you when required.

At each visit, please bring your insurance card with you and be prepared to pay the co-payment or deductible. If you are considered a full pay patient, please be prepared to pay the agreed upon amount. Payment is requested at the time of your appointment.

New Patients: Please arrive thirty (30) minutes before your scheduled appointment to complete the registration forms.

Existing Patients: Must complete new registration forms annually.

EMAIL POLICY Unfortunately, we do not provide this service due to enormous volume of spam email. At this time we do NOT accept emails for appointment requests/cancellations or prescription refill requests. ***CALL THE OFFICE for urgent medical situations – PLEASE DO NOT USE EMAIL***

TELEPHONE CALL POLICY If you are having an emergency of a medical nature, please call 911 immediately. Routine calls and messages are given to the appropriate person as soon as possible, and every attempt is made to return telephone calls during regular working hours. There are times, however, when we cannot answer all calls within the same day they are received. Please leave a message and someone from our staff will call you at the earliest possible time.

TEST RESULT POLICY It takes a minimum of 3 days to receive test results. You will be notified of any **abnormal** test results. If you have not heard from the clinical staff within this time, please call the clinic.

HANDICAP ACCESSIBILITY We want to ensure that your visit to our clinic is as convenient and comfortable as possible. There are several handicap accessible parking spaces in front of the entrance to the building. The inside of the building is a smoke-free environment. The office restroom is ADA compliant.

PRESCRIPTION REFILL POLICY

The Psychiatrist will make the final determination for all prescription refill request.

1. No prescriptions are refilled for more than 60 days without an office visit and is determined by the type of psychotropic medication prescribed.
2. No refill request via telephone will be accepted. Feel free to have your pharmacy fax the refill requests for review to 706-357-5468.
3. We will make every attempt to answer all Rx requests within 24-48 hours M-F.
4. Under no circumstances are certain psychotropic medications prescribed without an office visit.

By signing, you are stating that you are in agreement with the above policies and procedures listed for Eastern Atlanta Behavioral Health, LLC.

_______________________________________ _______________________________________

Patient/Legal Guardian/Parent Signature **Date**

We thank you for selecting Eastern Atlanta Behavioral Health, LLC to provide your behavioral health services. Every effort will be made to provide you with quality care, professional support, respect and consideration. Please inform our staff immediately should there be questions or concerns

ASSIGNMENT FOR BENEFITS

I, ________________________________ authorize Eastern Atlanta Behavioral Health (EABH) to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to EABH.

INFORMED CONSENT

I agree and consent to participate in behavioral health care services offered and provided by Eastern Atlanta Behavioral Health (EABH) and behavioral health providers. I accept the conditions for receiving services from EABH. I(we) have reviewed a copy of EABH's Notice of Privacy Practice and policy and procedures. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within (1) the scope of the provider's license, certification, and traning; or (2) the scope of license, certification, and traning of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorize to initiate and consent to treatment on behalf of this individual.

Signed:____________________________________ Date:__________________________________

Relationship to Patient (if applicable):____

Witness:___________________________________ Date: __________________________________

1353 Jennings Mill Rd Suite C, Watkinsville, GA 30677
706-357-5467 Office *** 706-357-5468 Fax

MEDICAL HISTORY

Name:____

Mental Health Hospitalizations:

Year	Name of Hospital	Condition

Surgeries:

Year	Type

***Other serious medical conditions:**____
____

Current medications:

Name	Dosage	Schedule

History of Tobacco use? Yes No **History of Drug use? Yes No** **History of Alcohol use? Yes No**

Are you allergic to any medicines? YES NO If yes, which?_______________________________________

Have you ever had a seizure? YES NO If so, when was the last time?_____________________________

Have you had a loss of consciousness? YES NO If so, when was the last time?_______________________

Name of any mental health doctors you have seen in the last 3 years:

1.____
2.____
3.____
4.____

1353 Jennings Mill Rd Suite C, Watkinsville, GA 30677
706-357-5467 Office *** 706-357-5468 Fax

HIPPA Georgia Notice Form

Notice of Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Eastern Atlanta Behavioral Health, LLC and its agents may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

o Treatment is when your health care provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your health care provider consults with another provider, such as a family physician or another psychologist.

o Payment is when your health care provider obtains reimbursement for your healthcare. Examples of payment are when your health care provider discloses your PHI to your health insurer to obtain reimbursement for your health care provider or to determine eligibility for coverage.

o Health Care Operations are activities that relate to the performance and operation of the practice of Eastern Atlanta Behavioral Health, LLC

"Use" applies only to activities within the health care provider practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of the health care provider's practice such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

Eastern Atlanta Behavioral Health, LLC may use or disclose PHI for purposes outside of treatment, payment, or health care operation when your appropriate authorization is obtained. An "Authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your health care provider is asked for information for purposes outside of treatment, payment or health care operations, your health care provider will obtain an authorization from you before releasing this information. Eastern Atlanta Behavioral Health LLC will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes your health care provider has made about conversations with you during private, group, joint, or family counseling sessions. These are kept separate from the rest of your medical record and are given a greater degree of protection than PHI. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your health care provider has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides that the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

Your health care provider may use or disclose PHI without your consent or authorization in the following circumstances:

Suspected child abuse or dependent (vulnerable) adult or elder abuse. (The therapist is required by law to report this to the appropriate authorities immediately)

If a client is threatening serious bodily harm to another person or persons. (The therapist must notify the police and inform the intended victim)

If a client intends to harm himself or herself or lacks the capacity to care for him or herself. (The therapist must make every effort to enlist the client's cooperation in ensuring their safety. If the client does not cooperate, further measures must be taken without the client's permission in order to keep the client safe, i.e. calling 911.)

Prenatal Exposure to Controlled Substances. (Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.)

Judicial and Administrative Proceedings- where the licensee is a defendant in a civil, criminal, or disciplinary action arising from the therapy, in which case client confidences may be disclosed in the course of that action.

When there is a valid court order for the disclosure of client files. (This is very rare and will be reviewed by our attorney before handing anything over to the courts.)

To comply with laws relating to workers' compensation and similar laws.

Health Oversight Activities: If provider is subject of an inquiry by the Georgia Board of Psychological Examiners, provider may be required to disclose protected health care information regarding you in proceedings before the Board.

Other uses and disclosures of PHI not described in this notice will be made only with your authorization.

Patient's Rights

Right to Request Restrictions- You have the right to request restrictions for certain uses and disclosures of protected health information but we are not required to agree to a restriction at your request. However, we will comply with a restriction request if (except as otherwise required by law), the disclosure is to a health plan for purposes of carrying out payment or health care operations and (2) the PHI pertains solely to a health care item or service for which you or another person has paid us, in full, out-of-pocket. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations- You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. (i.e., you may not want your family member or roommate to know that you are seeing a therapist. On your request, we will leave messages at an alternative location or bill to another address.)

Right to Inspect and Copy- You have the right to inspect or obtain a copy (or both) of PHI in your health care provider's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your health care provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and the denial process.

Right to an Accounting- You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

Right to be Notified of a Breach - You have the right to be notified in the event that we discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to a Paper Copy- You have the right to obtain a paper copy of the notice from this office upon request, even if you have agreed to receive the notice electronically.

Complaints

If you have questions about this notice, disagree with a decision this office makes about access to your records, or have other concerns about your privacy rights, you may contact your provider at this office at 706-357-5467.If you believe that your privacy rights have been violated and wish to file a complaint with this office, you may send your written complaint to Eastern Atlanta Behavioral Health 1353 Jennings Mill Rd. Suite C Bogart, GA 30622.You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services and we can provide you with the appropriate address upon request.

Effective Date, Restrictions, Changes to Privacy Policy

This notice went into effect on September 23, 2013. This office reserves the right to change the terms of this notice, make restrictions or limitations, and make the new notice provisions effective for all PHI if this occurs we will notify our clients.

I have read and received a copy of the notice of GEORGIA HIPPA NOTICE - Notice of Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

Print Name:_________________________________**Signature:**_____________________________**Date:**______________

Witness:_______________________________________ **Date:**___________________________