Psychiatric Associates of Atlanta, LLC
Building 12, 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

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 the person responsible for the bill is other than the 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 or Medicaid):

Drs. Lipsig and Norman have opted out of Medicare. You will be responsible for fees incurred. This requires you and your doctor to enter into a separate contract.

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

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.

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 Sec. Code 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, 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.

PAYMENT/INSURANCE INFORMATION:

Fees are due at the time services are rendered. Our physicians do not contract with any insurance companies. However, if your insurance company provides out-of-network benefits, you may file your own claims for reimbursement. These claims should be paid directly to you. At the end of each appointment, you will receive a statement that contains the necessary documentation to file with your insurance company. We recommend that you contact your insurance company for specific information about your out-of-network coverage for mental health services.

In addition, our physicians have opted out of Medicare. If you have Medicare, you can be seen on a Private Contract basis, in which no Medicare claims are made. Please click here to download the contract. We do not accept Medicaid.

We accept credit and debit cards as a convenience.

Please note that each physician sets his own fees independently. For current fee schedules, please call our office.

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 your email correspondence and these communications should be considered part of your 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:

Routine brief phone calls made between the hours of 8:30 a.m. and 3:00 p.m. on weekdays will be returned as quickly as possible; calls will typically be returned the same day. Routine calls received after 3:00 p.m. or on weekends will be returned the following business day.

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.

MEDICATION REFILL POLICY:

Medication refills will generally be called in to the pharmacy within one business day after the request is made. When requesting a refill, please provide:

- Your date of birth
- Name of medication requested
- Medication dosage
- 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.

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 that agreements be made regarding 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 indicates that I have read the notice of privacy practices.

Signature: _____ Date: _____