PSYCHIATRIC SERVICES at brookstone

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Patient Information (please print clearly)

Date:_____

Full Legal Name:_____ SSN:_____

DOB:_____ Sex:_____ Martial Status:_____

Address:_____ City:_____

State:_____ Zip:_____

Best Contact Phone #:_____

May we leave messages at: Home Cell Work (please circle all that apply)

Email:_____

Occupation:_____ Education:_____

Emergency Contact (name & number):_____

Primary Care Physician:_____

Signature & Date:_____

Briefly describe your reasons for seeking treatment, current symptoms and difficulties:

List significant physical problems/diagnosis past or present along with dates:

List **ALL** current medications, including dosage, starting date and prescribing physician. Please be as accurate as you can be.

Any allergies? _____

Are there any special circumstances or problems that you are concerned with (i.e., legal, financial, work, family?)

Previous psychological and/or psychiatric treatment or hospitalization? Dates, therapists, reason for therapy, location of facility, outcome:

Describe any drug/alcohol abuse; include 1) current use, 2) amount and 3) history of abuse/dependency treatment

Primary Insurance: _____

Policy/Subscriber ID #: _____

Group #: _____

Policyholders Full Name: _____

Policyholders DOB: _____

Policyholders SSN: _____

Secondary Insurance: _____

Policy/Subscriber ID #: _____

Group #: _____

Policyholders Full Name: _____

Policyholders DOB: _____

Policyholders SSN: _____

PLEASE READ ALL STATEMENTS BELOW, THEN SIGN AND DATE.

I authorize the release of any medical information necessary to process my claim

I authorize payment of medical benefits to **Psychiatric Services at Brookstone.**

If person signing below is anyone other than the patient, please provide your name, relationship to the patient, and contact phone number and/or legal documentation allowing you to sign in lieu of the patient.

Signature: _____ Date: _____

Do we have your permission to send a letter of acknowledgement to the person or physician referring you to our office? **If yes please sign below if not then leave blank.**

Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)

This section contains summary information about HIPAA, which is a new federal law that provides new privacy protections and new patient's rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this agreement, better explains HIPAA and how it relates to your PHI. The law requires that we obtain your signature acknowledging that we have provided you with this information in writing. Although these documents are long and sometimes complex, it is very important that you read them carefully. When you sign these documents it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Confidentiality

All communications between patient and provider will be held in confidence, and will not be revealed to anyone unless you or your court appointed representative (or parent in case of a minor) give written authorization to release this information. Your legal right to privileged communication will be upheld unless overruled in a court of law during a legal proceeding. Georgia Law requires that confidentiality be waived when the patient's or other's personal safety is threatened, or when disclosure of child/elder abuse is made to the provider. If we determine that a patient presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying potential victim, and/or contacting the police, and/or seeking hospitalization for the patient. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Occasionally, your provider may choose to consult colleagues about your case. During these consultations, your identity will be protected. We request that you complete a "Release of Information" so that we may be in contact with your personal physician or referring physician. Information that is routinely released to insurance companies for reimbursement for services shows only a diagnosis, date of service rendered, charge and payment details.

You may recognize people here. We expect you to maintain confidentiality concerning the identities of these people. If it is necessary to contact you, we will be discrete. As with most offices, **Psychiatric Services at Brookstone** employs administrative staff. Sharing your PHI with these individuals is necessary. All staff members have been given training about protecting your privacy and have signed an agreement not to release any information outside of the practice without the permission of Dr Kevin McPherson, or a professional staff member.

Un-emancipated Minors

Patients under 18 years of age along with parent or legal guardian should be aware that the law allows parents to examine the treatment record of the minor patient unless I/we believe that doing so would endanger or be counter-therapeutic. For teenagers privacy is often crucial for successful progress, which is why (sometimes) it is my policy to meet with the minor patient and discuss an agreement from parent or guardian that they consent to give up access to minor patient records. If an agreement is reached, only general information about the progress of the child's treatment will be given along with a reminder of future appointments.

Communication with Provider

Often times I am not available by telephone. While I am usually in the office between 9 am and 5 pm, I am with patients. During the times I am unable to speak with you, our staff will make every effort to speak with you or return your call. If you leave a voicemail during business hours please be as detailed as possible and the best way to reach you should you require a return phone call. After hours, weekends, and/or holidays, our answering service will be available for you to leave a message.

If you are unable to reach me during normal business hours or wait for a return phone call, contact your family physician or you are concerned about harming yourself or others, please call **911** or go to the nearest emergency room.

FOR AFTER HOURS EMERGENCIES THERE WILL BE A $25.00 MINIMUM FEE

Medication and Refill Requests

If you need a refill of your medication please call our office during business hours. If you need to leave a message please include the following: **Name, date of birth, medication name, dosage information, quantity, preferred pharmacy and, a contact phone number where you can be reached**.

In many cases, I will be able to refill your medication without any further consultation. However, at my discretion I may request an appointment to discuss medication before a refill is authorized. Only under special circumstances will I change the current dosage without an appointment.

I require, at minimum, 48 hr notice for refill requests. No requests will be filled on the weekends or holidays. You may call the office during business hours, Monday thru Thursday 830-5 pm to request refills. On Fridays requests after 12:00 pm will not be filled until the following Monday.

Controlled Substances: Examples

Stimulants:	1) Adderall	2) Concerta
Anxiety Med:	1) Clonazepam	2) Ativan
Sleep Med:	1) Ambien	2) Lunesta

Are just a few examples and numerous others not listed, are required to have a face to face encounter at least every 90 days. These medications will **NOT** be refilled over the phone. Please refer to the "Controlled Substance Prescription Agreement" you received when you were first given the details of the medication. You may also refer to the attached policy that you signed prior to becoming a patient of Psychiatric Services at Brookstone.

Should I or the administrative staff be unavailable for an extended period of time (more than 2 days), arrangements for another physician to be responsible for medication refill requests. This physician will unlikely refill controlled substances, but is at the discretion of the physician on call.

Late Cancelation/ No Show Policy

We reserve time for each person(s) scheduling an appointment; and our income is based entirely on the hours we see patients. If someone cancels late or misses an appointment, we incur a loss of income for that amount of time and are not able to offer that time to someone who may be waiting, possibly in crisis. Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, we need to have ample notice in order to avoid this type of loss.

Regardless of cause, Psychiatric Services at Brookstone requires that you give your doctor 48 hour notice in order to release you from your responsibility for that time scheduled. **You will be billed for late cancelations and missed appointments. Please note that insurance companies do not reimburse or pay for cancelled sessions**. If you have circumstances that may make it difficult for you to keep your appointments, please discuss this with your doctor during your intake session. We will try to accommodate every patients schedule as much as possible.

Transfer of Care Policy

If you are moving or transferring car to another physician, or have been discharged from the practice, we will make every effort to help in your efforts for a smooth transition. This may include discussions with other providers and provision of medical records if you request it. In general, if you have not been seen in over 6 months, care is assumed to be completed.

Electronic Communication Policy

Psychiatric Services at Brookstone and Dr. McPherson may choose to communicate electronically, via email, or text messaging. However, communication through our office telephone number, in writing, or in person is preferable to these communication methods. We attempt to keep all communication confidential, but it is important to understand that electronic communication is susceptible to compromise.

Financial Arrangements and Co pays

The Initial appointment without insurance is $250.00; follow-up visits are $165.00 for a 20-30 minute session, or $110.00 for a 5-15 medication management appointment.

It is required to pay prior to any services rendered unless other arrangements have been made prior to appointment date or a payment plan is in place.

Interest charges may be added to the balance on accounts beyond 60 days past due. Collection procedures may/will be pursued after 60 days.

COPAYMENT, IF ANY, IS DUE AT TIME OF SERVICE.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment and may provide out of network benefits. **We bill your insurance as a courtesy but ultimately it is your responsibility to make sure you are covered for visits and/or treatments. It is very important that you find out exactly what mental health services your insurance policy covers and if you need to obtain preauthorization.** If your employer offers an Employee Assistance Program (EAP), it's your responsibility to inform our office of this coverage. You must provide the billing address, telephone number, and number of visits authorized. Please note, we cannot guarantee payment for EAP services that are contracted through another facility. Our office is not contracted with all EAP programs. If you have questions about the coverage, call you plan administrator. "Managed Health Care" plans such as HMO and PPOs often require authorization before they provide any benefit for out of network physicians. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more consultations after a certain number of sessions. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services provided to you. We are required to provide clinical diagnosis, additional clinical information such as treatment plans or summaries, and copies of your entire PHI. In such situations, we will make every effort to release only the minimum information about you and your treatment. By singing the Agreement, you agree that we can provide the requesting information to your insurance carrier. **Also, you have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].**

Legal Proceeding/ Additional Fees

If you become involved in legal proceedings that require participation, you will be expected to pay for my professional time, including preparation, transportation costs, and lodging expense if required. This policy is in effect even if I am called to testify by another party. **Because of the complexity in legal procedures, Dr McPherson charges $300 per hour for preparation, attendance, and any consultation time with attorneys.**

Additional fees for services including but not limited to, report writing, telephone conversations clinical in nature, consulting with other professionals on your behalf, preparation of records in regards to treatment plans, and any other specialized requests that are outside the "normal" scope of this practice. These services will be billed on an individual basis. Each patients needs are different, therefore the billing will be different. **The minimum fee for any services requested is $110 per hour.**

Checks that are returned for Non-Sufficient Funds will carry a $35 penalty. If payment is not received within 10 days by money order, cash, or cashier's check, collection proceedings will be initiated.

We accept Visa/MasterCard/Am Ex/Discover, and many others. Personal Checks, cash, and money orders are also acceptable.

Upon request we can set-up an automatic payment for monthly appointments or past due balances. Please see the front office staff for more information.

Sexual Harassment

The most productive and satisfying work environment is one in which work is accomplished in a spirit of mutual trust and respect. Harassment is a form of discrimination that is offensive, impairs morale, undermines the integrity of patient relationships and causes serious harm to the productivity, efficiency and stability of our practice.

All employees/patients have a right to be in an environment free from discrimination and harassing conduct, including sexual harassment. Harassment on the basis of a patient or employee's **race, color, creed, ancestry, national origin, age (40 and over), disability, sex, arrest or conviction record, marital status, sexual orientation, membership in the military reserve or use or nonuse of lawful products away from work is expressly prohibited under this policy**. Harassment on any of these bases is also illegal. This policy will be issued to all current or future employees and patients.

This policy also expressly prohibits retaliation of any kind against any employees or patients bringing a complaint or assisting in the investigation of a complaint. Psychiatric Services at Brookstone views harassment and retaliation to be among the most serious breaches of work place behavior. Consequently, appropriate corrective action, ranging from a warning to dismissal from the practice, can be expected

Office hours are 8:30-5:00 Monday through Friday.

My signature below indicates I have read the policies and procedures outlined above, and will abide by the rules Psychiatric Services at Brookstone has in place.

Signature (s): _____ Date: _____

Psychiatric Services at Brookstone

Dr. Kevin McPherson

Controlled Substance/Prescription Agreement

Medications are controlled for medical and legal reasons. If not used properly they can cause problems. If sold for street use they contribute to addiction and crime. Dr. McPherson and Psychiatric Services at Brookstone MUST manage these medications in a way that is medically appropriate and that meet all Federal and State regulations. Please read the following carefully. **By signing, you are agreeing to follow the terms listed below in this agreement. Exceptions cannot and will not be tolerated.**

Please initial on line provided after every clause

Controlled substances are habit forming and can cause physical dependence. Suddenly stopping the medication may cause physical withdrawal symptoms. These symptoms may include flu-like feelings, crawling skin, sleeplessness, irritability, anxiety, and even seizures. I understand I may develop physical dependence from medications. _____

I understand that patients with a history of substance abuse, including alcohol abuse, are at high risk of relapse from certain medications. Patients with a strong family history are also at high risk for potential addiction. I have notified Dr. McPherson and Psychiatric Services of any family history of substance abuse to include alcohol abuse/dependence. _____

I understand that my medication may not be taken more often than prescribed. If your medication is not working, you must contact the office. Controlled medications will NEVER be refilled more than 2 days early. If you run out of medication for whatever reason, you may suffer withdrawal if Dr. McPherson is unable to refill your medication. _____

I will notify Dr. McPherson within 24 hrs if I receive pain medication, sleeping pills, tranquilizers, or other controlled substances from any other doctors (including emergency room doctors). I understand that I may be dismissed from the practice if I do not notify Psychiatric Services that I have received controlled medications from another source. I also understand that obtaining controlled medications from more than one doctor without notifying all physicians who prescribe for me is a felony. The only exception is medication taken during an inpatient hospitalization. _____

To get medication refills, I must be seen at least every 90 days. I understand it is my responsibility to schedule and keep all appointments. I understand that if I have not been seen in 90 days, no medication can be refilled until seen at the office. _____

I understand that I am receiving medications that are at high risk of being stolen. I am responsible for protecting my medications. Dr McPherson cannot replace stolen medications without a police report filed with local law enforcement agencies and a copy retained for our records. _____

I understand that selling, trading, or giving a medication to another person, including a family member is illegal. _____

I understand that Dr. McPherson fully cooperates with all law enforcement agencies. If I violate any clause of this contract, Dr. McPherson and Psychiatric Services MUST consider that I may be abusing or selling medications. They will report suspicious activities to the appropriate agencies for further investigation. In such instances, doctor-patient confidentiality does not prevent doctors from providing pertinent information to law enforcement. _____

I understand that medication refill requests can be made by telephone during business hours, Monday through Thursday 8:00-5:00 and Friday 8:00-12:00 pm. No refills will be made after office hours or on weekends. Please allow 48 hrs for a response to your requests. The front office will call when the medication is ready to be picked up or that we have sent your medications to the pharmacy of your choosing. _____

It is the policy of Dr. McPherson and/or Psychiatric Services to occasionally perform urine drug tests on those patients taking potent medications. There may, or may not be a cost to the patient for these tests, but we will be unable to prescribe medications to any patient who refuses a test no matter what the reason. _____

I give my permission for Dr. McPherson and Psychiatric Services to contact any pharmacy, physician, or hospital to specifically discuss my medications whenever they feel it is indicated. _____

Most patients are medically capable of driving once they have adjusted to taking their medications on a regular basis. However, laws in most states consider anyone driving while taking sedating medication(s) to be under the influence (DUI). In such cases, it does not help or matter if your doctor believes it was safe for you to drive. _____

I understand that a violation of any clause in this agreement contract may be grounds for termination of care.

Patient Name: _____

Signature: _____ Date: _____

Physician Signature: _____ Date: _____

GEORGIA NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
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.

What is "Protected Health Information" or PHI? It's information that identifies who you are and relates to your past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available, or that is in a summary form that does not identify who you are.

Purpose of this Notice

In the course of doing business, we gather and maintain PHI about our consumers. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of your PHI. We are obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards. We are also obligated to explain this Notice to you.

How We Protect your PHI

We restrict access to your PHI to only those employees who need access in order to provide services to our consumers. We have established and maintain appropriate physical, electronic and procedural safeguards to protect your PHI against unauthorized use or disclosure.

Types of Use and Disclosures of PHI We may Make without your Authorization

Federal and state law allows us to use and disclose your PHI in order to provide health care services to you, as well as bill and collect payments for the health care services provided. For example, we may use your PHI to review the quality of care provided by your psychiatrist/therapist.

We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our participating psychiatrist/therapist. We may also use or disclose your PHI, to inform you about health-related benefits and services that we offer, or to contact you to remind you about appointments. We conduct these activities to provide behavioral health care to you, and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may use or disclose your PHI to perform certain business functions with our business associates, who must also agree to safeguard your PHI as required by law. We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law – In some circumstances, we are required by Federal and state laws to disclose certain PHI to others, such as public agencies for various reasons.
2. Reports about child and other types of abuse or neglect
3. Other health care providers
4. For lawsuits and other legal disputes
5. To avert a serious threat to the health or safety of your or other members of the public
6. For national security and intelligence/military activities – Such as protection of the President or foreign dignitaries, and in connection with services provided under workers' compensation laws

We may disclose your PHI without your written authorization, if you are the legal parent and maintain control your minor child's PHI. In some cases, however, we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission. There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. All other uses and disclosures of your PHI must be made with your written authorization.

Your Rights Regarding your PHI

You have the right to review and request a copy of your PHI from our practice. If we provide you with a copy, we may charge a reasonable administrative fee for copying, printing or faxing your PHI to the extent permitted by law.

Right to Amend Your PHI

You have the right to request amendments to your PHI. If you wish to have your PHI corrected or updated,please write to us and tell us what you would like changed and why.

Right to Receive a Copy of This Notice

You have the right to request and receive a paper copy of this Notice.

Right to Request Restrictions

You have the right to request restrictions on how we use and disclose your PHI for our treatment, payment, and health care operations. All requests must be made in writing.

Right to Confidential Communications

You have the right to request in writing that we provide your PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternate means (e.g., sending by a sealed envelope, rather than a post card) or to an alternate address (e.g. calling you at a different telephone number, or sending a letter to you at your office rather than your home address). We will accommodate any reasonable requests, unless they are administratively too burdensome, or prohibited by law.

Right to Complain

We must follow the privacy practices set forth in this Notice while in effect. If you have any questions about this Notice, wish to exercise your rights, or file a complaint; please direct your inquiries to:
Provider
11180 State Bridge Road Ste. 205
Alpharetta, GA 30032

You may contact your Health Plan with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.

Rights Reserved

We reserve the rights as expressed in this Notice.