StrongTower Behavioral Healthcare

3750 Palladian Village Drive, Suite 110
Marietta, Georgia 30066
Tel. (678) 265-8361
Fax (888) 965-5219

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Sex: M F SSN: _____

Home Phone: _____ May we leave messages at home? Y N

Work Phone: _____ May we call you at work? Y N

Cell Phone: _____ May we leave messages on your cell? Y N

Email Address: _____ May we contact you by email? Y N

Street Address: _____

City: _____ State: _____ Zip: _____

Place of Employment/School: _____

Name of Emergency Contact: _____

Phone Number: _____ Relationship: _____

Primary Insurance: _____

ID: _____ Group Number: _____

Policy Holder: _____ Relationship: _____

Secondary Insurance (if applicable): _____

ID: _____ Group Number: _____

Policy Holder: _____ Relationship: _____

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Do you currently see a Primary Care Physician? Y N

If yes: Name of PCP: _____

Do you currently see a therapist? Y N

If yes: Name of therapist: _____

Do you currently take <u>any</u> prescription medications? Y N

If yes, please complete below:

Medication Name	Medication Dosage	Medication Frequency

Preferred Pharmacy: _____

Address: _____ City/State/ZIP: _____

As a psychiatric practice, <u>we do not offer therapy</u>. Would you like to receive a list of therapists? Y N

PYSCHIATRIST-PATIENT SERVICES AGREEMENT
TREATMENT CONSENT
STRONGTOWER BEHAVIORAL HEALTHCARE, LLC.

Welcome. This document contains important information about this practice and its business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law designed to protect your privacy and your rights about the use and disclosure of your Protected Health Information (PHI) used for treatment, payment, and health care operations. HIPAA requires that we provide you with the attached Notice of Privacy Practices that explains HIPAA and how it affects you. The law also requires that we obtain your signature acknowledging that you have received this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can address any questions you have about the procedures before your next session. When you sign this document, it will also represent an agreement between yourself and your provider. You may revoke this agreement in writing at ant time. That revocation will be binding except for the information already disclosed; obligations imposed on us by your health insurer to process or substantiate claims made under your policy or if you have not satisfied any financial obligations incurred.

MENTAL HEALTH AND CONSULTATION SERVICES

Services vary depending on your needs, and your psychiatrist's approaches. Aside from treatment with medications there are many different methods used to deal with the issues that you hope to address.

Your initial session(s) will Involve an evaluation of your needs. By the end of the evaluation, your psychiatrist will be able to offer you some first impressions about indication for meditation and what your work would include along with a plan to follow, if you decide to continue with our services. You should evaluate this Information along with your own impression of whether you feel comfortable working with your provider. Treatment/consultation involves commitment of time, money, and energy, so you should be careful about the provider you select. If you have questions about procedures, please feel free to discuss them whenever they arise. If your doubts persist, your provider will be happy to help you set up a meeting with another professional for a second opinion.

APPOINTMENTS

When an appointment time Is scheduled, you will be responsible to attend the appointment unless you provide at least 24 hours' notice of cancellation or need to reschedule, you are financially responsible for the time you reserve. Please note that insurance companies do NOT provide reimbursement for cancelled sessions. Cancellations on the day prior to the scheduled appointment need to be made by phone. Same day cancellations and/or no showed appointments are subject to a $50.00 fee.

Please request refills for medications at the beginning of a session or call your pharmacy to fax a refill request. If medications need to be called in by phone, a fee of $10 will be charged, please allow two business days for refill requests to be processed.

Initial appointments are scheduled for a duration of 60 minutes. Medication management (follow-up) appointments are scheduled for a duration of 20 minutes.

PROFESSIONAL FEES AND PAYMENT

Your provider has a fee schedule for out-of-network services. In-network-services will be provided according to your insurance plan fee schedule. If there are questions, please discuss this during your visit, If you want to set up a payment plan, you may also discuss this during your visit.

You will be expected to pay for each session at the time it is held, preferably at the beginning of the session, unless another schedule is agreed upon or unless you have insurance coverage. If we file your insurance, you are expected to make your co-pay at each visit. Payment schedules for other professional services (such as report writing, extended telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, or legal testimony) will be agreed to when they are requested. We accept credit card and personal checks. There will be a $35 service charge for returned checks.

If your account has not been paid for more than 60 days and you have not made arrangements for payment or worked out a payment plan with your provider, we have the option of using legal means to secure the payment. This may include collection agency or small claims court, which will require disclosing otherwise confidential Information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due- if such legal action is necessary, these costs will be Included In the claim.

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Privacy Notice

This Privacy Notice Is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use your protected health information to carry out treatment, payment, or health care operations and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health Information in some cases. Your protected health information means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created of received by your health care provider, and that related to your past, present, or future physical health or mental health conditions.

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you, we must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice, The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Ope Akinnusi MD, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at StrongTower Behavioral Healthcare or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below.

U.S. Department of Health and Human Services

Office of the Secretary

i200 Independence Avenue

Washington, D.C. 20201

Tel: (202) 619-0257

Toll Free: 1-877-696-6775

http:/www.hhs gov/contacts

StrongTower Behavioral Healthcare, LLC

Michael Cabena

3750 Palladian Village Drive, STE 110,

Marietta, GA 30066

Tel: 678-265-8361

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HIPAA NOTICE FORM
State of Georgia

Notice of physician's policies and practices to protect the privacy of your health information: This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**
   Protected health Information (PHI) may be disclosed for treatment, payment, and health care operations purposes with your consent, To help clarify these terms, here are some definitions:
   -Protected Health Information (PHI): PHI refers to Information In your health record that could identify you.
   -Treatment Is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
   -Payment Is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your insurer to obtain reimbursement or to determine eligibility or coverage.
   -Health Care Operation are activities that relate to the performance and operation of my practice. Examples of health Care Operation are quality assessment and improvement activities and care coordination.
   -Use applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
   -Disclosure applies to activities outside of my practice such as releasing, transferring, or providing access to Information about you to other parties.

2. **Uses and Disclosures Requiring Authorization**
   I may use or disclose PHI for purposes outside of treatment, payment, or health care operations 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 I am asked for information for purpose outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. You may revoke any authorization at any time, provided each revocation is in writing. You may not revoke an authorization to the extent (1) I have relied on that authorization or (2) If the authorization was obtained as a condition of obtaining Insurance coverage, law provides the insurer the right to contest the claim under the policy. Disclosures required by health Insurers or to collect overdue fees are discussed elsewhere in this Agreement.

3. **Situations where psychiatrists are required to disclose information without authorization:**
   -If your psychiatrist believes that a patient/client presents an imminent danger to his/her health or safety, they may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
   -If you are involved in a court proceeding and a request is made for Information concerning the professional services that are provided to you, such information Is protected by the psychiatrist-patient privilege law, Information cannot be provided without your written authorization or a court order. If you are Involved In or contemplating litigation, you should consult with your attorney to determine whether & court would be likely to order us to disclose information.
   -If a government agency Is requesting the Information for health oversight activities, we may be required to provide It for them.
   -If a client files a complaint of lawsuit against a psychiatrist, that psychiatrist may disclose relevant information regarding that patient/client In order to defend him/herself.
   -If a client files a workers' compensation claim, and services are being compensated through workers' compensation benefits, a psychiatrist must, upon appropriate request, provide a copy of the patents/client's records to the alien's employer or the Georgia State Board of Workers' Compensation.

4. In addition, there are some situations in which we are legally obligated to take actions necessary to attempt to protect others from harm and which may require revealing some information about a patient's/client's treatment. These situations are unusual in this practice. They Include the following:
   -If there Is cause to suspect that a child under 18 is abused or neglected, or reasonable cause to believe that a disabled or elderly adult is in need of protective services, the law requires that a report be filed with the County Divestor of Social Services. Once such a report is filed, additional Information may be required.
   -If there is reason to believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose Information In order to take protective actions, Including Initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.
   If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit disclosure to only what Is necessary,
   While this written summary of exceptions to confidentiality should prove helpful In informing you about potential problems, it is Important that any questions or concerns that you may have now or in the future be discussed. The laws governing confidentiality can be quite complex. In rare situations where specific advice Is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, your psychiatrist may keep Protected Health Information about you [in two sets of professional records. One set constitutes your Clinical Record: it includes Information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, medications prescribed, types of therapy approaches provided, the goals that are set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records received from other psychiatrists/psychologists/therapists, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except In unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and your psychiatrist believes that access is reasonably likely to cause substantial harm to such other person or to yourself, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your psychiatrist or have them forwarded to another mental health professional so you can discuss the contents. (There may be a charge for copying records)
The exceptions to this policy are contained in the attached Privacy Notice. If your request for access to your records is refused, you have a right of review, which will be discussed with you upon request,

In addition, your psychiatrist may also keep a sat of Psychotherapy Notes. These Notes are for your psychiatrist's use and are designed to assist In providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations with your psychiatrist, an analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive Information that you may reveal to your therapist that Is not required to be Included In your Clinical Record and information revealed to your therapist confidentially by others.

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NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 01/12/21

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, 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, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment, and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and any other practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply,
5. Request an amendment to your protected health information. However, we may deny your request for an amendment if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003), incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protested health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. Receive notification if affected by a breach of unsecured PHI.

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient's Name: _____ Date of Birth: _____

I hereby acknowledge that I have received a copy of StrongTower's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____, but acknowledgement could not be obtained because:

- ☐ Patient/representative refused to sign.
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt to obtain acknowledgement again at a later date).
- ☐ Communication barriers prohibited obtaining acknowledgement (explain):
  _____
  _____
  _____

- ☐ Other (specify):
  _____
  _____
  _____

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OFFICE POLICIES

Prescription Refill Policy

In order to provide quality care, StrongTower Behavioral Healthcare providers adhere to a strict prescription refill policy. Medication refills are best requested during your office visits with our providers, as any new or ongoing symptoms are addressed at such times. We understand, however, that sometimes this is not possible, and in those situations, our refill policy will apply. It is your responsibility to notify the office in a timely manner when refills are necessary, Approval of your refill may take up to three (3) business days, so please be sure to plan ahead, Medication refills will only be addressed during regular office hours (9:00 AM to 5:00 PM), We are unable to honor refill requests during after-hours, Please contact the office on the next business day to place your refill request.

In order to effectively process your prescription refill request, we will need the following information:

-Date that the request is made
-Spell your first and last name
-Your date of birth
-Spell the name of the medication and dosage
-Date that the current prescription will run out
-State how you are currently taking the medication
-Name and phone number of your pharmacy
-Contact information where we can reach you

The following guidelines will be utilized when processing your refill request:

-There will be NO refills given on Friday's after 12 PM, weekends, or Holidays,
-A process time of 3 days will be needed for all requests,
-Regular office visits are required for refills. Refill requests from patients that have not been seen in 5 months or more will be denied,
-If an appointment is missed or cancelled, patients are required to reschedule. Enough refills until the next appointment will be provided in that Instance,
-There will be no early refills especially for controlled substances, patient must follow prescription directions,
-Prescription medications that are lost or stolen will not be replaced,
-No refills will be processed for prescriptions not initiated by StrongTower providers.
-Some medication refill requests will require a follow up appointment,
-New symptoms and/or events will require an office appointment,

By signing below, I understand, agree, and accept the policy listed above. Failure to comply may result in denial of refills or immediate termination of certain prescriptions.

Patient/Parent/Legal guardian Signature: _____

Print Name: _____ Date: _____

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OFFICE POLICIES

New Patients

A. Appointment confirmation: failure to confirm the appointment (in response to the texts, voicemails sent by the practice for this purpose) 24 hours prior, may lead to cancellation of the appointment.
B. Payments: Copay is DUE AT the time of service. For self-pay patients, full payment for the appointment is due AT the time of the appointment. Failure to do so may result in the cancellation of the appointment.
C. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.
D. In the event of a no-show, a $50.00 charge will be billed to the responsible party.
E. In the event a patient arrives late to their appointment, patients will be required to reschedule.

Minors/Incapacitated Persons

A. Minors: must be accompanied to all appointments by an adult, parent, or legal guardian. While 17-year-olds are allowed to attend appointments unaccompanied, all desired changes in medication will require parental consent. Relevant documents are required, and will be kept in the patient's chart:

-Evidence of legal guardianship will be required for minors being accompanied by adults who are not their biological or adopted parents. In the case of divorced parents, a copy of the custodial agreement (which states who has medical making decisions rights), will be required from the custodial parent who accompanies the minor to their appointment.

-A parent or legal guardian may wish for another adult to accompany their minor to the appointment on their behalf. In this instance a sighed, notarized letter from the parent authorizing the named adult to do so is required. This must be accompanied by a copy of a valid, government issued ID, for both the parent and the referenced adult.

Failure to abide with any or all of the above will result in cancellation of the appointment.

B. Incapacitated Adults: must be accompanied to all appointments by an adult, Relevant documents are required, and will be kept in the patient's chart:

-Evidence of legal guardianship will be required for intellectually disabled individuals being accompanied by their parents or other legal guardians.

-A parent or legal guardian may wish for another adult to accompany their intellectually disabled ward on their behalf, In this instance a signed, notarized letter from the parent/legal guardian, authorizing the named adult to do so is required, This must be accompanied by a copy of a valid, government issued ID, for both the parent and the referenced adult.

-For all other incapacitated adult patients, evidence of documentation of healthcare power of attorney is required from accompanying adults. Failure to abide with any or all of the above will result in cancellation of the appointment.

By signing below, I understand, agree, and accept the policy listed above.

Patient/Parent/Legal guardian Signature: _____

Print Name: _____ Date: _____

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OFFICE POLICIES

Appointment Disclosure

We understand that there are times when you must miss a scheduled appointment dye to emergencies or obligations for work or family, However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment, Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

By signing below, I understand that Strong Tower Behavioral Healthcare has a missed appointment and cancellation fee in effect, and I understand that in the event I no show for my scheduled appointment or cancel my appointment less than 24 hours from my appointment date and time, I will be subject to a $50.00 fee. I understand that If I am charged this fee; It will be due and payable at my next scheduled appointment.

By signing below, I understand, agree, and accept the policy listed above.

Patient/Parent/Legal guardian Signature: _____

Print Name: _____ Date: _____

Insurance Authorization & Assignment/Financial Statement

I hereby authorize StrongTower Behavioral Healthcare, LLC to be my treating providers and to provide Insurance carriers information concerning my illness and treatment, and I hereby assign to StrongTower Behavioral Healthcare, LLC all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand that all co-pays, deductibles, or coinsurance is due at the time of service, no exception, unless prior arrangements have been made. I am responsible for providing StrongTower Behavioral Healthcare, LLC with correct insurance information. StrongTower Behavioral Healthcare, LLC will bill my insurance as a courtesy to me and if my insurance does not pay within 90 days from my date(s) of service, I am aware that I will be billed for the balance and held responsible for the amount in full. I also understand that if I do not satisfy my financial obligation and have an outstanding balance with the clinic, further services may be denied to me by StrongTower Behavioral Healthcare.

By signing below, I understand, agree, and accept the policy listed above.

Patient/Parent/Legal guardian Signature: _____

Print Name: _____ Date: _____

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Please complete below if you would like to authorize us to communicate with another individual or provider's office involving details of your treatment at StrongTower Behavioral Healthcare.

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize StrongTower Behavioral Healthcare to use and/or disclose my protected health information as described below to (name and address of recipient):

_____

for the following purposes (describe each purpose of disclosure - If disclosing different types of information below. For different purposes, the authorization must specify the purpose for which each type of information is being disclosed.):

_____

I understand that:

1) THIS AUTHORIZATION IS VOLUNTARY AND | MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE
2) I have the right to request a copy of this form after | sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164,524).
3) | may revoke this authorization at any time by notifying STBHC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining Insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy,
4) STBHC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

- ☐ Assessment
- ☐ Testing Information
- ☐ Diagnosis
- ☐ Educational
- ☐ Psychological Evaluation
- ☐ Continuing Care Plan
- ☐ Psychosocial Evaluation
- ☐ Progress in Treatment
- ☐ Treatment Plan or Summary
- ☐ History
- ☐ Current Treatment Update
- ☐ Billing Records
- ☐ Presence/Participation in Treatment
- ☐ Other:
  _____
  _____

In addition, I authorize that this may include health information relating to HIV/AIDS infection, Drug/Alcohol abuse, and/or Genetic Testing.

Expiration: This authorization will expire 180 days from the date of signing or (insert date) _____

Patient/Parent/Legal guardian Signature: _____

Print Name: _____ Date: _____