Psychiatric Professionals of GEORGIA

Benjamin Akosa M.D.
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Heerain Shah M.D.

Your Journey to Wellness

New Patient Form

Patient Demographics:

Name (First, MI, Last): _____ Birthdate: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email: _____

Parent/Guardian name: _____ Parent/Guardian phone: _____

Insurance (Primary):

Company Name: _____ ID #: _____ Phone #: _____

(Secondary):

Company Name: _____ ID #: _____ Phone #: _____

EMAIL ID AND INSURANCE CARDS TO Referrals@PsychiatricProfessionals.com

Visit Information

Reason for Visit/Current Diagnosis: _____

Verbal: Yes ☐ No ☐ **Requires Supervision or Aide to attend visit**: Yes ☐ No ☐

Risk taking or Dangerous Behavioral: _____

_____

Primary Care or Referring Doctor: _____ Phone #: _____

Family Members at home: (Spouse, Parents, Children, Siblings, Other) _____

_____

Current Medical Illnesses: _____

Medication Allergies: _____

Current Pharmacy: _____

List all **CURRENT** medications: (include dosage and frequency):

_____

List all **PRIOR** Psychiatric medications: (include dosage and frequency):

_____

_____

Prior Psychiatric History: (**Inpatient Admission with dates**, Previous Providers, Prior Dx, Testing, Etc.…)

_____

_____

_____

Signature: _____ Print Name: _____ Date: _____

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Practice Policies

Thank you for choosing Psychiatric Professionals of Georgia for your health care needs. As part of your relationship with Psychiatric Professionals of Georgia, a clear comprehension of our office policies is important so you will understand office procedures, individual responsibilities, financial liability, and the extent and limits of various forms of communications. These polices may be updated over time for which you will be notified. Current office policies are also listed on the website, www.PsychiatricProfessionals.com.

X_____ **Appointments**

Appointments can be requested by telephone, patient portal, or email.

Appointments will be confirmed by text/email ahead of time; however, it is the patient's/guardian's responsibility to keep track of the appointment to avoid charges for missed or cancelled appointments.

Appointments can be cancelled by the provider if the patient is more than 10 minutes late to their appointment. The patient will be subject to the full charges.

X _____ **Cancellations/Missed Appointments**

If an appointment is cancelled less than 2 business days in advance, or missed, the patient/guardian is subject to a no-show fee of $50.

After 2 missed appointments within 1 calendar year, the patient will be sent a warning letter regarding office policy.

After 3 missed appointments within 1 calendar year, patient will be at risk of being dismissed from the practice.

X _____ **Charges & Payments**

Payment is due at the time of service. CASH or CREDIT CARD (Visa and MasterCard) are the only acceptable forms of payment.

Current Cash Rates:

New Patient Visit: Medical Doctor- $325, Physician Assistants & Nurse Practitioner's- $275

Follow-up Visit: Medical Doctor- $225, Physician Assistants & Nurse Practitioner's- $175

Rates are subject to change, but the patient/guardian will be notified by the time of scheduling an appointment.

The adult accompanying a minor to a session, even if they are not the legal guardian, will be responsible for payment at the time of the service. Arrangements for advance payments can be made.

There may be charges for services provided outside of regular appointments. Such as Labs, ADHD testing, records request, Letters, and Forms. Please reference online under New and existing patient tab.

X _____ **Payment Policy**

Psychiatric Professionals of Georgia is committed to providing you with quality care. To achieve this result, we must highlight that as your provider, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy, we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits. Please direct any questions concerning your coverage to your insurance company.

Proof of current, valid insurance must be provided at time of service. If you do not provide this information, you will be considered a self-pay patient and will be required to pay the full charge prior to being seen.

We participate in most insurance plans; however, it is your responsibility to check with your plan prior to your visit to make sure we are participating providers.

We will gladly file your claims to your health insurance; however, we do not file automobile, general liability, homeowner's, or workman's compensation insurance.

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If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your primary care provider (PCP) prior to being seen. If you fail to obtain this information, the bill will be your responsibility and you will be required to pay the full charge prior to being seen.

Payment is due at the time of service. If you are unable to pay your copayment, your appointment will be rescheduled, and you will be billed a rescheduling fee.

Failure to receive your statement does not relieve you of your financial obligations

It is your responsibility to notify us of any changes in your billing information.

We accept cash and most major credit cards. We DO NOT accept CARE CREDIT.

Past due accounts are subject to our collections process and dismissal as a patient.

A fee will be incurred for the completion of forms, letters, including disability and FMLA. The office staff can inform you of the specific charge.

X_____ **Medication Refills**

Medications will be refilled at each appointment if it is clinically appropriate so that patient will not run out before their next appointment

If due to a missed appointment a patient runs out of medications,

the non-controlled medication(s) will be refilled one time only (if deemed clinically appropriate by the treating psychiatrist) until next available appointment.

the controlled medication(s) will be refilled one time only for up to 30 days (if deemed clinically appropriate by treating psychiatrist) and an appointment must be made within that timeframe to be evaluated in person.

Medication Refills will not be performed in the following cases:

After office hours

Over the weekend

During Holidays

For Individuals who repeatedly miss appointments

If there is suspicion of abuse of medications

X _____ **Prior Authorizations**

PPG will provide services for Prior Authorizations if needed.

Prior Authorizations can take up to a week after provider approval to receive an approval or denial from insurance company

X _____ **Forensic Policy**

Should providers from Psychiatric Professionals of Georgia be subpoenaed to appear in court or provide testimony via phone, Consultation services are billed at $900 per hour, in half hour increments (1 hour minimum). The amount is to be paid to Psychiatric Professionals of Georgia prior to services rendered.

X _____ **E-mail**

Risk of using Email: Psychiatric Professionals of Georgia offers patients the opportunity to communicate via a patient portal that is secure. We strongly encourage use of the patient portal for communication. However, you may also email PPG at Psychiatry@PsychiatricProfessionals.com. Do not send emails to any other email address you may come across. Transmitting patient information by unsecured e-mail has a number of risks that patients should consider. These include, but are not limited to, the following risks:

E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.

E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.

E-mail senders can easily misaddress an e-mail.

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E-mail is easier to falsify than handwritten or signed documents.
Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
E-mail can be used to introduce viruses into computer systems.
E-mail can be used as evidence in court.

We cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by our unintentional misconduct.

Providers may forward e-mails internally (within Psychiatric Professionals of Georgia) to staff and agents as necessary for treatment and other patient needs. We will not, however, forward e-mails to independent third parties.

All e-mails to or from the patient concerning diagnosis or treatment will be made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and counselors, will have access to those e-mails.

The patient/guardian is responsible for protecting his/her password or other means of access the patient portal. Psychiatric Professionals of Georgia is not liable for breaches of confidentially caused by the patient/guardian or any third party.

Psychiatric Professionals of Georgia shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

It is the patient's/guardian's responsibility to follow up and/or schedule an appointment if warranted.

X _____ **Telephone**

Please call with any urgent, clinical questions. We will return you call within 48 hours but earlier if possible.
Please do NOT leave a message in case of emergencies. See emergency procedures below.
Text messaging is NOT an acceptable form of communication

X _____ **Emergency Treatment**

If for some reason, you cannot reach Psychiatric Professionals of Georgia directly and patient/guardian deems there is an emergency, they are directed to call 911 or go to the nearest emergency room for immediate services. You may also call the Georgia Crisis and Access Line at 1-800-715-4225 or the National Suicide Hotline at 1-800-273-8255 (1-800-SUICIDE).

X _____ **Confidentiality**

In the course of therapy with a child, it is important for Psychiatric Professionals of Georgia to gain his/her trust for therapy to work. Although legally a guardian has access to a child's record, please understand that in order for a child to build this trust, material revealed in one-to-one sessions should be maintained confidential between the provider and the child. However, if it is determined that a child is doing things or is exposed to things that are life endangering, the guardian will be notified.

All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law.

Disclosure may be required in the following circumstances:
Where there is a reasonable suspicion of child abuse or elder adult physical abuse
Where there is a reasonable suspicion that the patient presents a danger of violence to others, or where the patient is likely to harm him or herself unless protective measures are taken. Pursuant to a legal proceeding.

X _____ **Conduct and Dress Code**

Patients/guardians are required to abide by the clinic policies.
Patients and/or guardians are required to wear appropriate shoes and clothing.
Disruptive or aggressive behavior can lead to dismissal from the clinic.

X_____ **Items Not Allowed**

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Food and/or beverage is not allowed on office premises.
Use of tobacco products, including any e-cigs or vapes, are not allowed on clinic grounds.
Weapons or firearms are not allowed on clinic grounds.

X _____ **Consent to Provide Treatment**

Psychiatric Professionals of Georgia may provide treatment in the form of medication therapy, psychotherapy, laboratory testing, diagnostic procedures, and other appropriate alternative treatments.

You have the right to:
Be informed of and participate in the selection of the treatment methods and plan
Receive a copy of this and all consents as well as request your records at any time
Withdraw any consent at any time

PATIENT/GUARDIAN ACKNOWLEDGEMENT
I acknowledge that I have read and fully understand PPG *Practice Policies* above.
I acknowledge that I have read and fully understand PPG *Financial Responsibilities, HIPAA Notice of Privacy Practices, and Controlled Substances Agreement* that are available on our website or in office.
I understand the limitations of Psychiatric Professionals of Georgia availability to the client and emergency procedures.

Patient's name: _____ Patient's signature:_____

Parent/Guardian name: _____ Parent/Guardian signature:_____

Date: _____

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ANNUAL CONSENT

Patient Name: _____DOB: ____/____/_____

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

I **DO** authorize information to be released to the following:

Tell us with whom we may discuss your protected health information:

1. _____ **Relation:** _____

Phone or email: _____

2. _____ **Relation:** _____

Phone or email: _____

3. _____ **Relation:** _____

Phone or email: _____

4. _____ **Relation:** _____

Phone or email: _____

I **DO NOT** authorize information to be released to anyone but myself.

Signature: _____ **Date**____/____/____

Print Name: _____

Email: _____