

Amanda E. Williams, M.D., Inc.: Confidential Patient Information

Patient Name: _____
Date of Birth: ____/____/____ Age: ____ Social Security # ____ - ____ - ____
Home Address: (No PO box #s) _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Phone: _____
Work Telephone: _____
At what number(s) may we leave a message? _____
Emergency Contact (Name and Phone): _____
Marital Status: Single Married Divorced Widowed Occupation: _____
Employer: _____
Employer Address: _____
Referred by: _____

Billing Information

Person responsible for payment: _____
Address (include city/state/zip): _____
Home Telephone: _____ Work Telephone: _____
Cell Phone: _____

Are you covered by medical insurance? No, I am Self-Pay (skip this section) Yes (complete this section)
Do you have a co-pay? No Yes and it is \$ _____ Do you have a deductible? No Yes and it is \$ _____

Primary Insurance Information:

Insurance Company: _____ Phone # (____) _____
Address of Insurance Co.: _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Relationship to Patient _____
Identification no. _____ Group no. _____

Secondary Insurance Information (if applicable):

Insurance Company: _____ Phone # (____) _____
Address of Insurance Co.: _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Relationship to Patient _____
Identification no. _____ Group no. _____

Office Policy

PAYMENT IS EXPECTED AT TIME OF APPOINTMENT. I PARTICIPATE WITH ONLY SOME INSURANCE COMPANIES. IT IS YOUR RESPONSIBILITY TO DETERMINE IF I AM A PARTICIPATING PROVIDER OR NOT.

IF I AM NOT A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY AND YOU HAVE OUT OF NETWORK BENEFITS: THIS OFFICE IS NOT RESPONSIBLE FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT. AT EACH VISIT, I WILL PROVIDE YOU WITH A STATEMENT OF SERVICES THAT CONTAINS ALL THE INFORMATION YOU NEED TO FILE YOUR CLAIM WITH YOUR INSURANCE CARRIER.

A FULL CHARGE (\$190 FOR 45-50 MIN APPTS AND \$120 FOR 20-30 MIN APPTS) IS MADE IF APPOINTMENT IS CANCELLED LESS THAN 24 HOURS IN ADVANCE.

I HAVE READ THE ABOVE AND PROVIDED THE INFORMATION TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Signature Patient

Date

Printed Name

Amanda E. Williams, M.D., Inc.: Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and make a note of any questions that you may have so that we can discuss them during our meeting.

Meetings

My normal practice is to conduct an evaluation which will last from 1 to 3 sessions. By the end of this evaluation I will be able to offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. During this time, we can both decide whether I am the best person to provide the services which you need in order to meet your treatment objectives. You should evaluate this information along with your own assessment about whether I am a person with whom you feel comfortable working with. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about my appropriateness, we should discuss them whenever they arise. If your doubt persists, I will be happy to help you secure an appropriate consultation with another mental health professional.

If psychotherapy is initiated, I will usually schedule one 45-50 minute session per week at a mutually agreed time. Once this appointment hour is scheduled, you will be expected to pay the full fee of this session unless you provide **24 hours** advanced notice of cancellation (or unless we both agree that you were unable to attend due to circumstances which were beyond your control).

Please see the cancellation policy at the end of this document.

Should our work involve medication monitoring only, it is expected that you will continue psychotherapy with the therapist who referred you to me until such time as we all agree it is no longer needed.

Medication monitoring appointments last 20-30 minutes and will vary in occurrence based on your medication needs.

Professional Fees

Initial Assessment \$240 for the first hour and \$190 each subsequent hour.

Individual Psychotherapy with or without Medication Management (45-50 min.) \$190.00

Individual Psychotherapy with or without Medication Management (20 -25 min.) \$120.00

Medication management only (20-25 min.) \$120.00

Family Therapy with or without patient present (60 min.) \$220.00

Returned Check Fee \$30.00

In addition to weekly appointments, it is my practice to charge this amount (\$190/hour) on a prorated basis for other professional services you may require such as letter writing, telephone conversations which last longer than 10 minutes, attendance to meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. In the event that you should have an outstanding balance on your account, be aware that there is a late charge of \$15 per month added to the balance on any amounts owed for over 30 days from the date of the invoice.

Insurance Reimbursement

I am a participating provider for only a few insurance carriers. It is your responsibility to determine if I am a participating provider with your specific insurance company. If I am a participating provider, I will accept payment directly from your insurance company for services rendered. You will be responsible for any and all co-pays, co-insurance, and deductibles which will be due at the time of service.

If I am not a participating provider with your insurance company, then I am considered an "out-of-network" provider and I will not file insurance claims from my office. If you have out-of-network benefits, you can file a claim directly with your insurance carrier for reimbursement of all or part of the fees you have paid me. You, and not your insurance company, are responsible for full payment of the fee which we have agreed to. At each visit, I will provide you a statement of services that contains all the

Amanda E. Williams, M.D., Inc.: Outpatient Services Contract

information you need to file your claim. In order for us to set realistic goals and priorities, it is important to evaluate what resources are available to pay for your treatment. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. If you have questions, you should call your insurance carrier to inquire about outpatient out-of-network mental health services.

Contacting Me

I am often not immediately available by telephone because I am unable to take calls when I am with another patient. When I am unavailable, my telephone is answered by automatic voicemail which I monitor frequently. I will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available.

If you are having an emergency and feel you cannot wait for me to return your call, you should dial 911 or go to the nearest emergency room and ask for the psychiatrist on call. As soon as you are able, you should contact me through the answering service to let me know what has taken place.

If you are calling after 5pm on weekdays or on the weekend **and** you absolutely must speak to me before the next business day, you may contact me via the answering service at **(770) 928-5044**.

If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact during my absence if necessary.

Prescriptions

You will receive prescriptions for an adequate supply of medication to last until your next appointment. As per government regulations, controlled substances such as Ritalin, Concerta, Focalin, Metadate, Dexedrine, and Adderall cannot be refilled and only a 30 day supply can be given at one time. This means that I am not able to give refills or call in prescriptions for these medications.

Prescriptions requested by phone during business hours will be called in within 24 hours. However, every effort will be made to call in your refills on the same day as your request. After 5pm Monday – Thursday prescriptions will be called in the next business day. Prescriptions requested by phone after 5pm on Friday will be called in the next business day (Monday).

Cancellation Policy

The scheduled appointment time is reserved exclusively for you. Therefore, if you must cancel your appointment, you must give **24 hours** notice. Otherwise, you will incur a charge for the appointment as if it had taken place and for the amount of the scheduled appointment. Monday appointments must be cancelled by no later than 12pm on Friday in order to avoid a charge. If I can fill your cancelled appointment time with another patient, you may not be charged the cancellation fee.

I look forward to working with you.

Amanda E. Williams, M.D.

**I. ASSIGNMENT AND RELEASE OF INSURANCE PAYMENT
(if applicable)**

I assign directly to **Amanda E. Williams, M.D., Inc.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for ALL charges WHETHER OR NOT paid by insurance.** This includes the unlikely circumstance when an insurance company requests a refund of an already paid claim. I am solely responsible for determining my own insurance benefits/coverage and obtaining and tracking any necessary pre-authorization for services. I hereby authorize the use of this signature on all my insurance submissions.

Signature _____ **Date** _____

MEDICARE AUTHORIZATION (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf to **Amanda E. Williams, M.D., Inc.** for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any health care information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature _____ **Date** _____

II. TREATMENT CONSENT

I hereby request treatment, medication and care as necessary and I agree to pay for such treatment and care as described in the representative fee schedule.

Signature _____ **Date** _____

III. RECEIPT OF OUTPATIENT SERVICES CONTRACT

I hereby acknowledge that I have received a copy of the Outpatient Services Contract of Amanda E. Williams, M.D.

Signature _____ **Date** _____

GEORGIA HIPAA NOTICE/PRIVACY PRACTICES

Notice of Psychiatrist's 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 UNDER THE NEW HIPAA LAWS. PLEASE REVIEW IT CAREFULLY.

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

I 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**" 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 healthcare provider, such as your family physician, psychologist or another psychiatrist.
- "**Payment**" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "**HealthCare Operations**" are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "**Use**" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "**Disclosure**" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or healthcare 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 purposes outside of treatment, payment or healthcare operations, I will obtain an authorization from you before releasing this information. I

will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes 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) 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.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Serious Threat to Health or Safety** – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- **Child Abuse** – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- **Adult and Domestic Abuse** – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted

upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- **Health Oversight** – If I am the subject of an inquiry by the Georgia Board of Medical Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- **Judicial or Administrative Proceedings** – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Worker's Compensation** – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- **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 at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying charges will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request.

Psychiatrist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the mailing address you provided.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at (404) 847-9560 or via U.S. mail at 1100 Johnson Ferry Road, Suite 1090, Atlanta, GA 30342-1744. You may also send a written complaint to the Secretary

of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Restrictions

I will limit the uses or disclosures that I will make as follows:

- I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:
- If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense
- When the following "Uses and Disclosures with Neither Consent nor Authorization" apply:
- **Child Abuse**
- **Adult and Domestic Abuse**
- **Health Oversight**
- **Judicial or Administrative Proceedings**
- **Serious Threat to Health or Safety**

**Amanda E. Williams, M.D., Inc.
1100 Johnson Ferry Road, Suite 1090
Atlanta, GA 30342**

Notice of Georgia HIPAA Notice/Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Printed Name of
Patient: _____

Signature of
Patient: _____

Date: _____

Patient's Date of Birth: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal
Representative: _____

Describe Personal Representative Relationship (e.g. guardian, HCPOA,
etc): _____

Signature of Personal
Representative: _____

Date: _____

Practice Use Only:

Signature of Practice Employee _____

Date: _____