

Atlanta Psychiatric Specialists, PC

Ross F. Grumet, MD

1718 Peachtree St., NW, Suite 1080

Atlanta, GA 30309

(T) 404-685-9414 (F) 404-685-9420

Treatment Agreement

OFFICE HOURS: Our office hours are Monday through Friday 9:00 am to 6:00 pm. We accept appointments from 9:20 am to 5:20 pm Monday thru Friday.

EMERGENCIES: An automated voice-mail system is available 24 hours a day, 7 days a week at (404) 685-9414 for emergency calls or cancellations. Messages left on our voice-mail system will be returned within one business day. In the event of a life threatening emergency, please call 911 or contact your local emergency services provider.

CANCELLATIONS AND NO-SHOWS: Missed appointments or appointments that are not cancelled at least 24 hours in advance will be charged an administrative fee of \$85.00. This fee is not covered by insurance. We will be unable to schedule any additional appointments until this fee has been paid. We offer a courtesy reminder call the day before scheduled appointments and document the time of these calls. Our reminder calls are a courtesy to patients and we are not responsible for appointments missed due to incorrect contact information or non-receipt of a voicemail message. It is your responsibility to keep your scheduled appointments.

INSURANCE: If you have health insurance and we are a participating provider with your plan, we will file a claim directly to your carrier. We will verify your coverage and provide you with an estimated financial responsibility for treatment. However, because coverage varies widely from plan to plan, we cannot guarantee that your plan will cover your charges. You are solely responsible for any charges incurred that are not covered directly by your plan or through any contractual arrangement we have with your carrier. If we are not a participating provider with your plan, we are unable to file a claim on your behalf and you will be responsible for all charges incurred. We will gladly provide you with an itemized receipt if you wish to file a claim with your carrier directly. If you have questions regarding the processing of your insurance claims, please direct those questions to your health insurance plan directly. **Remember, you are your own best advocate for any insurance issues.**

BILLING: You will receive a statement if there is a balance due. Balances not paid within 30 days are subject to a finance charge of 1.5% (18% annually). Should your account have to be assigned to collections, you will be responsible for all reasonable costs, including attorney's fees. We do not extend credit and the estimated patient responsibility of each visit and/or co-pay and/or deductible amount must be paid at the time of service.

COMPLETIONS OF FORMS: There is no charge for completing brief forms indicating therapy, medical visit or school absence. Completion of narrative reports, medical leave forms, letters of medical necessity, or other forms are subject to fees based on the complexity of the form and the amount of time required by the physician to complete it. These fees will be determined at the time the form or request is delivered to the office. **Payment is required before the forms are completed.**

PRESCRIPTION REFILLS: The Physician prescribes sufficient medication to last until the next visit and therefore requests for refills are generally not expected. As a general rule, our office does not call in prescriptions for patients. The Physician expects to see the patient to be sure the prescription is appropriate. **If an appointment is rescheduled or missed and medication is required, we charge a \$35 prescription call in fee. This fee is not covered by insurance and must be paid by the patient before any other services are rendered.** While we strive to handle all requests as soon as possible, medication requests require the signature of the ordering physician, and as such please allow **24 hours for our office to process prescription refill requests.**

PRIOR AUTHORIZATIONS: Some insurance plans require prior authorization for prescription medications. If your plan requires a prior authorization, please ask your pharmacy to fax the information to our office. We are generally able to process prior authorization requests within **48 hours of receipt of the information from your pharmacy.** It is ultimately up to your insurance carrier or pharmacy benefit manager to determine coverage for medications. We have no control over the length of time the prior authorization request may take, which may exceed **72 hours** in some cases. If you have any questions about your pharmacy benefits please contact your insurance carrier or pharmacy benefit manager directly.

TELEPHONE CONSULTS: In some cases Dr. Grumet may be able to discuss your care with you over the phone in lieu of an office visit. **This service is not covered by insurance.** Telephone consults are \$95.00 and must be paid in advance of the consultation. This service is handled on a case by case basis, and you will need to speak with the office manager to discuss this service.

Patient Signature: _____ Date: _____

Your signature acknowledges that you have read and accepted these policies. A copy will be given to you upon request.

Adopted: 07/11
Updated: 10/11

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE APPLIES TO THE INFORMATION AND RECORDS WE HAVE ABOUT YOU, YOUR HEALTH, AND ANY SERVICES YOU RECEIVE AT THIS OFFICE. WE ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. IT TELLS YOU HOW ATLANTA PSYCHIATRIC SPECIALISTS, PC (“APS”), EMPLOYEES AND OTHER OFFICE PERSONNEL MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU AND DESCRIBES YOUR RIGHTS AND OBLIGATIONS REGARDING THE USE AND DISCLOSURE OF THAT INFORMATION.

Definitions:

Protected Health Information, or “PHI” is information about you, your health status and your medical care that is maintained by this office. PHI may include demographic information, treatment information, evaluation reports and medical records from other sources.

Health Insurance Portability and Accountability Act, or “HIPAA” is a federal law that regulates how certain entities, including healthcare providers, may use and disclose health information about you. It also provides certain rights to patients regarding their health information.

We must have your written consent to use and disclose health information for the following purposes:

For Treatment. We may use health information about you to provide you with medical care or to recommend treatment alternatives that may be of interest to you. Office personnel may also disclose limited health information about you to an outside source in order to coordinate your care, such as authorizing treatments or prescriptions, or setting up a referral to another provider.

For Payment: We may use and disclose health information about you to secure payment for your treatment received at this office. If we are filing a claim with your insurance company, this means we may share information such as your diagnosis and treatment plan with them in order to secure payment.

For Healthcare Operations: We may use and disclose health information about you in the process of healthcare operations. We may also use health information about our patients to evaluate treatments, services and efficiency.

We may use or disclose information about you without your consent for the following purposes, subject to applicable state and federal laws:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner to assist in identifying a deceased person or determine a cause of death.

Family and Friends.: We may also disclose limited health information to a family or friend if we can infer, based on our professional judgment, that failure to do so may result in serious harm to yourself. We may also disclose certain information in a treatment setting if we receive verbal authorization. For example, we may disclose personal health information to your spouse if you bring your spouse with you into the treatment room.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with certain laws.

Information Not Personally Identifiable: We may use or disclose limited health information about you in a way that does not personally identify you or reveal who you are. We may use this information to evaluate services or treatment offered by this office. In certain limited circumstances, this information may be provided to another agency.

Law Enforcement: We may release health information to a law enforcement official in response to a court order, subpoena or similar process.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court order, subpoena or similar process.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces or part of the national security or intelligence communities, we may be required to release health information about you to military command or other government agency. We may also release information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability / or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We must have your written consent if the researcher will have access to personally identifiable information.

Worker's Compensation and Disability: We may release health information about you for worker's compensation or disability programs.

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect or copy certain portions of your health information maintained in our office. You must submit a written request to our office in order to inspect or copy your health information. We may charge a fee to cover the costs of copying or your records. The Health Information Portability and Accountability Act (HIPAA) places restrictions on a patient's right to access records relating to mental health treatment. If you have questions about how this may affect your right to inspect and copy your medical records, please speak with a member of our staff. If you are denied access to your records, you may ask that the denial be reviewed by an independent agent. If such a review is requested, we will select a licensed healthcare professional to perform the review and will comply with the outcome of the review.

Right to Amend. You have the right to request an amendment to medical information maintained at our office. You must make a written request to our office. We may deny your request if you ask us to amend information that we did not create or that we certify is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to our office. It must state a time period, which may not be longer than six years. We will notify you of any cost involved to provide this information to you and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restriction. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment. We will comply with all reasonable requests unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our office.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may submit your request in writing to the office manager. We will not ask you the reason for your request and will accommodate all reasonable requests.

Right to a Copy of This Notice: You have the right to receive a copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain such a copy, please contact our office.

Other Uses and Disclosure of Health Information: We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. We must obtain your Authorization separate from any Consent we may have obtained from you.

Special Restrictions for Mental Health, Substance Abuse and HIV/AIDS Treatment:

Federal law has placed special restrictions on access to mental health records, substance abuse records and records relating to diagnosis and treatment of HIV/AIDS. We will comply with all applicable regulations if we maintain records about you that fall under these categories.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact the office manager. You will not be penalized for filing a complaint.

Patient Signature: _____ Date: _____

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosure that occur before that time. If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE, AND TO MAKE THE REVISED OR CHANGED NOTICE EFFECTIVE FOR MEDICAL INFORMATION WE ALREADY HAVE ABOUT YOU AS WELL AS ANY INFORMATION WE RECEIVE IN THE FUTURE. YOU ARE ENTITLED TO A COPY OF THE NOTICE CURRENTLY IN EFFECT.

Adopted: 7/11 JPS
Revised: 10/2011

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Health History Questionnaire

All questions contained in this questionnaire are confidential
and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	Gender:	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous Psychiatrist (if applicable):		
Primary Care Physician Name (if applicable):		Date of last physical exam:
PERSONAL HEALTH INFORMATION		

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates (if available):	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Medication Name	Strength	Directions

Allergies to medications

Medication Name	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Questions in this section are used to assess your overall health. Please answer them to the best of your ability.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many meals do you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Have you been advised to reduce the amount of alcohol you consume?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered or attempted to stop consuming alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, why? _____			
	Have you ever experienced blackouts due to alcohol consumption?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what type of tobacco do you use?			
	<input type="checkbox"/> Cigarettes (Number of packs per day: _____)	<input type="checkbox"/> Chew (Amount per day: _____)	<input type="checkbox"/> Pipe	<input type="checkbox"/> Cigars (Number per day: _____)
	How many years have you used tobacco? _____		If you have quit, what year did you quit? _____	
	Would you like to discuss smoking cessation with the physician?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse is also a major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS (INCLUDE MENTAL ILLNESS)		AGE	SIGNIFICANT HEALTH PROBLEMS (INCLUDE MENATAL ILLNESS)
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MENTAL HEALTH (CONTINUED)

Have you ever been to a counselor or therapist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Name of counselor or therapist:				
Date of treatment:				
Have you ever had a psychiatric hospitalization?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, name of facility and dates of hospitalization:				
Have you ever been under the care of a psychiatrist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, name of provider and dates of treatment:				
Have you ever been prescribed psychiatric medications?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Name of medications:				

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Adopted: 5/04
Revised: 5/09
10/11

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Authorization for Release of Health Information for Coordination of Care

In order to ensure that you receive the best treatment, we would like to communicate with your primary care physician and therapist (if applicable). This communication will allow us to exchange pertinent medical information, such as lab results and medication records. Allowing us to coordinate care can be beneficial to addressing other health issues and reduce the risk of side effects and interactions between medications you are prescribed. ***This form is optional, and your information will always be maintained in accordance with all privacy regulations.***

1. Patient Information:

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____

2. Physician, Therapist or Facility Information:

(Please complete a separate form if you would like us to coordinate care with more than one physician, therapist or facility.)

Primary Care Physician

Other Physician

Therapist

Name: _____

Address _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

3. Release of Medical Information:

To authorize Atlanta Psychiatric Specialists, PC and/or Ross F. Grumet, MD to communicate with the physician, therapist or facility named above for the purpose of **coordination of care**, please sign below:

(Signature of Patient or Authorized Representative)

(Date)

4. Additional Disclosures:

To protect your privacy, state and Federal regulations have placed additional restrictions on the release of records relating to the diagnosis and treatment of mental health conditions, substance use conditions, and HIV/AIDS. We may need to release limited information from these portions of your record (where applicable) to coordinate care. If you agree to this disclosure, please sign below:

(Signature of Patient or Authorized Representative)

(Date)

You may revoke or restrict this form at any time. It will automatically expire twelve months from the date signed. If you have questions about what information we transmit or would like to request a restriction related to this form, please speak with a member of our staff.