

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 that will typically require one session, but may require up to 3 sessions. I will then be able to offer you some initial impressions of what our work will include and an initial treatment plan. During this time, we can both decide whether I am the best person to provide the services 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.

Follow up appointments for medication monitoring will last 20-30 minutes and will vary in occurrence based on your medication needs (typically every 1-3 months). If you choose to initiate psychotherapy (talk therapy) with me alone or in addition to medication management, I will typically schedule a 50-60 minute session every 1-3 weeks at a mutually agreeable time. Established patients may schedule, cancel or change appointments online at www.atlantapsychconsultants.fullslate.com.

Cancellation and Late Arrival Policy

Your scheduled appointment time is reserved exclusively for you. Once an appointment is scheduled, **you will be expected to pay the full fee of the 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 be aware that insurance companies do not pay for missed visits and you will be responsible for the full fee, not the discounted insurance rate, for missed appointments. Monday appointments must be cancelled by no later than 12pm on Friday in order to avoid a charge.

If you are more than 20 minutes late for your appointment, every effort will be made to accommodate you. However, I cannot encroach on the appointment time of other patients. Therefore, you have the option to wait to see if an opening becomes available (and not be charged), or you will need to reschedule the appointment (and you may be charged).

It is the nature of psychiatric practice that occasionally a medical crisis arises which requires my attention and may cause me to run late for your appointment. Every effort will be made to inform you that I am running late and you will still be seen for your full appointment time. Unfortunately, I am unable to reduce the charges for these appointments. On the rare instance that I run more than 20 minutes late, you will not be charged if you decide to reschedule the appointment.

Professional Fees (effective Dec 8, 2020)

Initial Assessment \$400 (up to 90 min) and \$300 each subsequent hour.

Individual Psychotherapy with or without Medication Management (up to 60 min.) \$220.00

Individual Psychotherapy with or without Medication Management (up to 30 min.) \$160.00

Medication management only (up to 30 min.) \$160.00

Family Therapy with or without patient present (up to 60 min.) \$250.00

Prescription send-in fee if you do not make and keep a timely follow up appointment \$25.00

Because of contracts between insurance companies and pharmaceutical companies, some insurers prefer certain medications to others as a cost saving measure. Insurance companies may require physicians to obtain "prior authorization" from the insurance company for non-preferred medications. Please know that this process can be time consuming (and frankly, unnecessary for patient care). If a prior authorization requires more than 15 minutes to complete, there will be a charge of \$50. You will be notified before any lengthy prior authorizations are attempted so that you may decide if you want this service. You have the option to change to your insurance company's preferred medication if this is medically appropriate and available.

In addition to weekly appointments, it is my practice to charge \$220/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, completion of forms 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 advance. **Please note: I do not accept personal checks.** Payment may be made by cash, credit card, or debit card.

Prescriptions

I send electronic prescriptions for medication directly to your pharmacy of choice in adequate supply to last until your next appointment. Therefore requests for refills outside of appointments are not generally expected. If through either an error by me or your pharmacy you need refills between appointments, you will not be charged. However, if you do not schedule and keep appointments in a timely manner and then request a refill, you will be charged a prescription send-in fee of \$25, which must be paid before further services can be rendered. Prescriptions requested by phone during business hours will be handled within 24 hours.

Please note that due to the volume of time consuming, duplicate and often erroneous requests from pharmacies, **I require that you contact me yourself if you need a refill.** I cannot respond to requests from pharmacies as these are numerous and often inaccurate (due to such things as “automatic refills” that do not take into account the fact that I have already send in a new separate prescription for you medication or changed the medication). When your bottle indicates there are no refills remaining, please ask the pharmacy to check thoroughly to be sure that you do not already have a **new** prescription for your medication on file. I also recommend that you call your pharmacy to be certain your medication is ready to avoid an unnecessary trip to the pharmacy.

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 my receptionist or 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. However, please allow at least 24 hours for your call to be returned. If you are difficult to reach, please leave some times when you will be available.

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

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

If I am unavailable for an extended time, I will have a trusted colleague available whom you can contact during my absence if necessary.

I look forward to working with you.

Amanda E. Williams, M.D.

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

Patient Name _____

Name you prefer to be called _____

Date of Birth ____ / ____ / ____ Age ____ Social Security # ____ - ____ - ____

Address

_____ Street _____ City _____ Zip _____

Best contact number(s) _____ Main/Mobile _____ Work/Other _____

At what number(s) may we leave a message? Main/Mobile Work/Other

Email address (for appointment reminders/updates) _____

Marital Status: Single Married Partnered Divorced Widowed Separated

Occupation _____ Employer _____

How did you find me? referral from _____
 Google other internet search engine: _____
 Psychology Today

Emergency Contact:

Name _____ Relationship _____

Best contact number(s) _____

Office Policy

Payment is required at time of service and may be made by cash, credit, and debit cards.

PLEASE NOTE THAT I DO NOT ACCEPT CHECKS.

You will be charged the full fee if you cancel an appointment with less than 24 hours advanced notice. (\$220 for 50-60 min appts. and \$160 for 20-30 min appts.) PLEASE BE AWARE THAT WE DO NOT PROVIDE REMINDER CALLS.

_____ **initial here** When you provide your email address when booking an appointment, you will be automatically sent reminder emails (or text messages if you prefer) one week, two days and the day before your appointment. Please see the letter detailing the reason for my cancellation policy on the following page if you have concerns.

_____ **initial here** For those with insurance: I do not participate with any insurance companies. You are therefore responsible for full payment of your account at the time of service. If you have out-of-network benefits, you will be responsible for filing or collecting your insurance claim or for negotiating a settlement on a disputed claim. I will provide a statement of services that contains all the information you need to file your claim. Out-of-network reimbursement to you by your insurance plan can vary widely from plan to plan, but typically ranges from 30-80% of my fees.

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

Signature Patient

Date

Printed Name

Primary Care Physician Information

Name _____

Address _____

Phone _____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?

Yes _____

No _____

If Yes,

I, _____, give permission to Amanda E. Williams, M.D. to send a general statement notifying my primary care physician of my visit today. The information sent will be for coordination of care, and will be limited to a brief description of the problem area and /or diagnosis, and a general outline of treatment.

Patient Signature

Date

Dear Patient,

Many patients ask why I charge for missed appointments not cancelled with 24 hours notice. Your appointment time is reserved solely for you. When you are unable to keep it without at least 24 hours advanced notice, I am often unable to fill that time with another patient. Unlike other types of providers who may be able to schedule multiple patients per hour and even double book appointments, I schedule only 1-2 patients each hour so that I can take the proper time and give proper attention to the quality care you deserve. If you do not keep your appointment, I have no way to offset the expenses that I remain responsible for during that time (e.g. rent, staff, office supplies, insurance). Therefore, I cannot sustain a private practice and continue to be available to you and others without charging for my time.

Sincerely,

Amanda E. Williams, M.D.

Notice of Georgia HIPAA Notice/Privacy Practices Receipt, Treatment Consent and Receipt of Outpatient Services Contract

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

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

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

Signature _____ **Date** _____

MEDICARE PATIENTS ONLY:

Medicare authorization

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 agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services.

Signature _____ **Date** _____

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PATIENT NAME _____

Medical History – please list all medical conditions, surgeries, major illnesses or injuries

Medications – please list all current medications and dosages (medical or psychiatric)

Past Medications – please list all past psychiatric meds, dosages and duration taken

Allergies – all medication allergies and reaction if known –OR– NO known drug allergies

Family Psychiatric History – please specify which relative(s) for each condition

- depression _____
- anxiety or panic _____
- bipolar disorder _____
- schizophrenia _____
- alcoholism _____
- drug abuse _____
- completed suicide _____
- other (specify) _____

Substance Use History – please specify amount and frequency

	Past	Current
alcohol	<input type="checkbox"/>	<input type="checkbox"/> _____
tobacco	<input type="checkbox"/>	<input type="checkbox"/> _____
marijuana	<input type="checkbox"/>	<input type="checkbox"/> _____
cocaine	<input type="checkbox"/>	<input type="checkbox"/> _____
opiates	<input type="checkbox"/>	<input type="checkbox"/> _____
stimulants	<input type="checkbox"/>	<input type="checkbox"/> _____
ecstasy	<input type="checkbox"/>	<input type="checkbox"/> _____
other	<input type="checkbox"/>	<input type="checkbox"/> _____

Which pharmacy do you use? (name, location, phone number if known)

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Name _____ Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	A few days	Several days	Nearly daily
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Sleeping less than usual	0	1	2	3
Sleeping more than usual	0	1	2	3
Tired/low energy	0	1	2	3
Appetite less than usual	0	1	2	3
Appetite more than usual	0	1	2	3
Difficulty concentrating	0	1	2	3
Forgetful	0	1	2	3
Irritable	0	1	2	3
Crying/felt like crying	0	1	2	3
Restless or agitated	0	1	2	3
Feeling nervous anxiety or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Less interested in sex than usual	0	1	2	3
Feeling worthless	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself	0	1	2	3

If answer for final question above is greater than 1, please explain: _____

For any answers above of 1 or more, how difficult have those problems made it for you to do your work, take care of things at home or get along with other people?

- Not difficult at all** **Somewhat difficult** **Very difficult** **Extremely difficult**

Have you ever attempted suicide? **Y** or **N**

Have you ever been psychiatrically hospitalized? **Y** or **N**

Are you actively meeting with a therapist or counselor? **Y** or **N**

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

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.

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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, including to your health plan when services are paid in full out-of-pocket. 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. You also have the option of receiving your records in electronic form if records are kept in electronic form. 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.
- I will notify you of any breach of your unsecured PHI.

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 5605 Glenridge Drive NE, Suite 620, Atlanta, GA 30342. 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