Gwinnett Psychiatry, PC
170 Camden Hill Road, Suite F
Lawrenceville, GA 30046
Phone: (678) 226-2295 *www.gwinnettpsychiatry.com* *Fax: (678) 226-2296*

Terms and Conditions for Office & Tele-Medicine VISIT

To ensure the safety and privacy of our patients, we are updating our policies:

- Patient required to return the "New Patient Paperwork", along with the governmental picture ID and the picture of Insurance card(Front & Back), both picture ID and Insurance card must be emailed to the email address listed on the bottom of the last page of this paperwork. The rest of the paperwork can be sent to us by EMAIL/FAX/US MAIL. Once we receive the entire paperwork, we will call you to schedule.
- As for SELF PAY Patients, only picture ID is required
- Picture(s) of the paperwork is not ACCEPTED
- Two sided print out not accepted as well
- Patient must be present for every visit/session(insurance requirement)
- Patient(s) can **NOT** be in a public place. Its recommended that the patient be in a private place during the session to ensure the privacy and comfort.
- Patient must be properly dressed
- Patient(s) under the age of 17 must be accompanied with a parent/Guardian. The parent/guardian must be on the patient(s) registration forms.
- Patient can **NOT** be driving or in a moving vehicle

If these conditions are not met, the patient(s) will have to reschedule his/her appointment(s) for another day when the above requirements can be met. We can provide a work/school excuses and fax or email it if necessary. Please make sure prior to your appointment that you have a good WIFI/Internet connection and your device is set to access your camera and microphone.

Please keep in mind that there is a $50 no-show fee for each missed appointment, cancelled within 24 hours. Please be prepared to pay any co-pay and balance before the appointment. Please check our website for more information at www.gwinnettpsychiatry.com.

Thank You!
Office Manager

PATIENT REGISTRATION
CHILD

(Please print and complete all blanks)

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Patient Name: _____
(Last) (First) (Middle)

Address: Home Phone:
City, State, Zip: Cell:
Sex: Race: Date of Birth: SSN:

Patient School (Name / Address / Phone):

FATHER'S NAME/OTHER LEGAL GUARDIAN

Father's Name_____
Father's Date of Birth_____
Home Address_____
City/State/Zip_____
Home Telephone_____
Employer_____
Occupation_____
Address_____
City/State/Zip_____
Work Telephone_____
Social Security #_____
Marital Status
S M Sep Div W

MOTHER'S NAME/OTHER LEGAL GUARDIAN

Mother's Name _____
Mother's Date of Birth _____
Home Address _____
City/State/Zip_____
Home Telephone _____
Employer_____
Occupation_____
Address_____
City/State/Zip_____
Work Telephone _____
Social Security #_____
Marital Status _____
S M Sep Div W

Insurance Information:

Father's Insurance_____
HMO/PPO Name_____
Insurance Address_____
Subscriber_____
Relationship to Patient_____
ID #_____
Effective Date_____

Mother's Insurance _____
HMO/PPO Name _____
Insurance Address _____
Subscriber_____
Relationship to Patient _____
ID #_____
Effective Date _____

Other Coverage(through other Agencies):

Name of Organization_____
Address_____
City/State/Zip_____

Identification # _____
Effective Date _____
Expiration Date_____

Referring Physician OR Organization:

Full Name_____
Office Address_____
City/State/Zip_____
Office Telephone No._____
Specialty _____

Full Name _____
Office Address _____
City/State/Zip_____
Office Telephone No. _____

Emergency Contact Information:

Name _____
Phone _____

Relationship _____

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PATIENT CONSENT FORM

MEDICAL CONSENT: I request and authorize my provider(s), their associates and assistants and employees to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered advisable by my provider for my health, and well-being. This may include pathology, radiology, emergency services, and other special services and tests ordered by my provider(s). I acknowledge that no representations, warranties, or guaranties as to result or cures have been made to or relied upon by me.

CONFIDENTIALITY:
The law protects the privacy of communication between a client and Dr Rubina. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA. Your signature on this Agreement provides consent to the following activities:

I further authorize Dr. Rubina, her associates and assistants and employees to provide and perform such medical care:

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations in which the doctor is legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and Dr. may have to reveal some information about a client's treatment. If Dr. has a reason to believe that a child has been abused, the law requires that Dr. file a report with DFACS. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that a disabled adult or elder person has been abused, I am required to report that to the appropriate agency. Once such a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Please feel free to discuss any concerns or questions you may have about confidentiality.

RELEASE OF INFORMATION:
I hereby authorize the above provider(s) to release any medical information concerning my care, including copies of medical records, and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations or the insurer in connection with obtaining payment for the medical services rendered to me and/or independent contractors engaged by them.

ASSIGNMENT OF INSURANCE BENEFITS:
In consideration of any and all medical services, care, drugs, supplies, equipment and facilities forwarded by the above providers, I hereby irrevocably transfer to said provider(s) all insurance benefits now due and payable to me or to become due and payable to me under any insurance policy or policies, or any replacement policies thereof that might be applicable.

I understand that my obligation to pay all charges is not affected by the fact that I have insurance benefits, and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing above provider(s).

The above provider(s) and the patient or patient's representative hereby enter into the above agreements. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status and further certified that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

_____ Date_____
Patient's Signature/Person Authorized to Consent (Relationship)

I hereby certify that I have witnessed the signature(s) the patient and/or individual signing on behalf or for the benefit of the patient.

_____
Date Witness

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PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that Gwinnett Psychiatry, P.C. has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Gwinnett Psychiatry, P.C., I understand and acknowledge the following:

Gwinnett Psychiatry, P.C. has a privacy policy in effect in their office.

Gwinnett Psychiatry, P.C. has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.

Gwinnett Psychiatry, P.C. has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom, acknowledging that you have been advised of the privacy policy implemented by Gwinnett Psychiatry, P.C.

I have read and understand the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ **No,** I do not want a copy but I acknowledge the Privacy Policy exists

_____ Yes, I do want a copy of the Privacy Policy

_____
Patient's Name

_____ _____
Patient's Signature/Person Authorized to Consent (Relationship) Date

For more information contact the* Gwinnett Psychiatry, P.C. *at (678) 226-2295

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STATEMENT OF RESPONSIBILITY

The coverage your insurance program provides is calculated based on their allowed amount, minus any deductibles, co-payments and/or coinsurance amounts. These amounts are your share of the cost.

Pre-certification: or certification is obtained from your insurance company. If you do not obtain certification when required, your benefits will be reduced or denied. Your insurance certification of your care does not guarantee coverage.

Pre-Existing: Your insurance might have a pre-existing condition clause. Any condition that existed on or before your effective date may be considered pre-existing. These conditions may be excluded for a period of time.

Responsibility: The amount your insurance will pay is determined by them and is the amount they determine to be appropriate for the service rendered. They have the sole discretion to determine the allowed amount. Your insurance company has the sole discretion to determine whether care is medically necessary. They will not cover care they feel it is not medically necessary. Therefore, it is your responsibility to cover any and all charges not paid by your insurance company.

Prescription Refills: Please allow 48 hours for all prescription refills, providing the patient account is paid in full. Prescription refills requested on Friday will be called in on Monday before noon. All controlled substance prescriptions will be issued only if the patient is present.

Unpaid Visits: If your insurance company has not paid for two prior visits, we will reschedule your appointment after payment has been received. You can continue to see the doctor if you agree to pay half of the actual fee, not contracted fee up front which will be reimbursed upon receiving payment from your insurance company.

Telephone Calls: Non-emergency telephone messages may be left with front office or voicemail. We will return your call as soon as possible. There is no charge for brief calls (less than 5 minutes). Calls of longer duration will be billed at the usual professional rate $300 per hour. Please understand that health insurance companies do not pay for telephone calls, but are provided to you as a convenience to you in your care.

Litigation cases: We do not accept new patient(s) involved in litigation such as child custody, divorce case & etc. As for established patient(s), all litigation cases must be paid in full before the services are rendered, since insurance companies do not reimburse for litigation cases(s). For more details please see the "fee schedule.

Medicare: We are not a Medicare provider therefore if you have Medicare or a Medicare Supplement plan through a commercial insurance, please notify us prior to being seen by the doctor otherwise you would be liable for all of the charges, including collection and attorney fees.

Gwinnett Psychiatry, P.C. will expect all payment of charges on the day services are rendered. Please come prepared to pay deductible amount not yet satisfied, charges not covered by your insurance, and co-payments. Patients are not allowed to discuss any financial matter(s) with the doctor.

I,_____, understand that I am responsible to pay my financial obligation in full. If for some reason, I am unable to pay this obligation in full when the balance is due, I will be held accountable for any and all late fees, collection fees, interest or finance charges, etc. that may accrue.

_____ _____

Signature of patient or Parent/ Guardian Date

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Gwinnett Psychiatry, PC

Fee Schedule

All litigation cases must be scheduled at least a month in advance so the doctor can schedule patients accordingly. The Commercial or Medicaid insurances **DO NOT** pay for any Litigation or Legal Consultation services provided by the doctor. A typical case incurs the following out of pocket charges:

• Consultation with patient & parent(s) in office or on the phone	$500/HR (1 hour min)*
• Consultation with attorney on the phone or in the office.	$500/HR (1hour min)*
• Any Disability Form/letter/Report written to any agency/institution	$500 each **
• Deposition in the office, plus min one hour case preparation $500	$500 per hour (min two hours)*
• Deposition other than Dr. Rubina's office, within 50 miles	$600 per hour (min two hours)*
• Court appearance, plus min one hour case preparation $500	$600 per hour (min two hour)*
• Commute between office & court & back to office	$ 600 per hour (min one hour)*
• Out of state Case(s)	$800 hour, plus Travel expenses

**************ALL ADDITIONAL TIME IS CHARGED IN 15 MINUTES INCREMENTS**************

• Diagnosis letter	free of charge
• Returned check fee	$50 (thereafter, cash/credit)
• Any non –legal letter (School forms, Katie Beckett & etc)	$50 per letter**

****All fees for letters and/or forms must be prepaid in advance before they are completed. If you are paying by check for the form completion fee, the forms will not be completed or released until the check has cleared.**

For all depositions and court appearances must be scheduled at least two weeks in advance, please schedule the doctor for maximum estimated time or schedule the doctor for the entire day (eight hours). Please bear in mind that the doctor will have patients scheduled for the rest of the day. Therefore, the doctor will leave right after your estimated scheduled time.

The estimated fees should be paid in full seven days before the services are rendered, unless the patient's attorney is guaranteed to pay on behalf of the patient. If the patient requires more time than estimated time, the balance should be paid right after the services are rendered.

In case of any court/deposition cancellation, please notify the office seven days in advance, otherwise you would be charged $500 per hour times the estimated time the doctor has allocated for you. The over-paid balance will be refunded to the patient within ten business days.

The above services are only provided to the established patients, whose accounts are paid in full at the time the services are requested.

Subpoena: If a patient / patients attorney issues a subpoena to the doctor without paying the consultation fee in advanced then the patient will be dismissed immediately from the practice.

I,_____ HAVE READ THE ABOVE POLICY AND UNDERSTAND IT FULLY.

_____ _____

Signature of patient or Parent/Guardian Date

Please be advised, all fees are subject to change without notice.

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Cancellation Policy

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone a **minimum of 24 hours** in advance. That way the open slot can be filled with someone needing an appointment.

Patients with Commercial Insurance(s):
If you do not cancel by the deadline, **you will be assessed a $50.00 missed appointment fee**. This fee is **not** covered by any insurance company and will be your responsibility to pay before your next visit. Most of the time we remind our patients a day before their appointments but we are not obligated. Therefore, this is patient's responsibility to keep track of his/her appointment.

Patients with Medicaid Insurance(s):

As of July 01, 2021 we must notify you that we are unable to reschedule an appointment if you have two no show appointments without proper 24 hour notice you will be discharged from the practice.

I HAVE READ THE ABOVE POLICY AND UNDERSTAND IT FULLY.

_____ _____
Signature of patient or Parent/Guardian Date

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Patient Demographic for E-Prescribe

Personal Information

Name: _____ **DOB:** _____

Address:_____

_____

Phone: _____(**C / H / W**)

Email: _____

Pharmacy Information

Name: _____ **Phone:** _____

Address: _____

_____

PLEASE LIST ALLERGIES AND SIDE EFFECTS

_____

_____

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CONSENT FOR TELEPSYCHIATRY

Introduction

Tele-psychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. The interactive electronic system used in Tele-psychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits

- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of Tele-psychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision-making by your provider.
- Your provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of confidential health information.
- A lack of access to all the information that might be available in a face to face visit, but not in a Tele-Psychiatry session, may result in errors in judgment.

Alternatives to the Use of Tele-psychiatry

- Traditional face-to-face sessions in your provider's office.

Patient's Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-psychiatry.
- I have the right to withhold or withdraw my consent to the use of Tele-psychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I have the right to inspect all medical information that includes the Tele-psychiatry visit. I may obtain copies of this medical record information for a reasonable fee
- I understand that my provider has the right to withhold or withdraw consent for the use of Tele-psychiatry during the course of my care at any time.
- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-psychiatry.

- I understand that all the rules and regulations that apply to the provision of healthcare services in the State of Georgia also apply to Tele-psychiatry.

Patient's Responsibilities

- I will not record any Tele-psychiatry sessions without written consent from my provider. I understand that my provider will not record any of our Tele-psychiatry session without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of an electronic equipment used on my computer which is used for Tele-psychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of Georgia to be eligible for Tele- psychiatry services from my provider.
- I understand that my initial evaluation will not be done Tele-psychiatry except in special circumstances under which I will be required to verify my identity.

Patient Consent To The Use of Tele-psychiatry

I have read and understood the information provided above regarding Tele-psychiatry. I have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Tele-psychiatry in my health care and authorize my provider to use Tele- psychiatry in the course of my diagnosis and treatment.

Patient Name: _____

Patient Date of Birth : _____

Note: Parent/Guardian signature required if patient is under eighteen

Patient/Parent/Guardian Signature: _____

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CHILD HISTORY FORM

Child's Name: _____

Date of Birth: _____ Today's Date: _____

Completed by: _____

Please describe any medical difficulty experienced by you or your child during

- Pregnancy with This Child:

_____

_____

_____

- Labor and Delivery:

_____

_____

Birth weight: _____ pounds _____ ounces

- Child in the First Days after Birth:

_____

_____

_____

- Child's First Year:

_____

_____

Describe any current or ongoing medical problem and medication (or other form of treatment) for this child:

(Continue on other side if needed.)

Describe any eating problems your child has.

Describe any sleeping problems your child has.

_____

_____

Please rate your child's progress in the following areas of development.

AREA OF DEVELOPMENT	SLOW	AVERAGE	FAST
Speech and Langauge			
Gross Coordination (running, walking and sports)			
Fine Coordination (writing and drawing)			
Socializing			
Describe any concerns in this space or above.			

Past Milestones: At what age did your child achieve the following skills?

AREA OF DEVELOPMENT	AGE CHILD ACHIEVED SKILL
Experience feeding difficulties or colic - Describe.	
Sit Alone	
Walk Alone	
Speak Real Words	
Speak Real Sentences	
Achieve Day and Night Bowel Training	
Achieve Night Bladder Training	
Achieve Day Bladder Training	

Describe your child's past medical history concerning the following events.

EVENT	AGE	REASON	RESULT
Hospitalization			
Surgeries			
Seizures			
Head Injuries			
Lengthy Medical Problems			
Medications Used for Long Periods of Time			

Describe any psychiatric evaluation or treatment your child has had.

AGE	REASON	WHERE	RESULT

Describe any hearing or visual problems your child has.

Vision	Hearing

Describe any problems your child is having now or has had in the past atschool.

Type of Problem	Present	Past
Academic		
Behavior		
Peer Relations		
Relationship to Teacher		
Concerns		

Where does your child attend school? _____

Grade _____

Type of School _____

List the schools (day care and current) yourchild has attended.

_____

_____

_____

_____

_____

Mention any special classes, repeated grades, and outside educational help your child has had or is now having.

SPECIAL CLASSES	REPEATED GRADES	OUTSIDE EDUCATIONAL HELP

Please include:

- Copies of individual education plans (IEP)
- Copies of school psychological testing
- Your child's report cards

Use this space to describe any other concerns you mayhave.

Your email:_____

Thank You!!!

Please email it back to:
gwpsych@gwinnettpsychiatr.com