Instructions for completing packet

First Page:

Complete entirely, in addition to your relationship to your emergency contact person.

The insurance portion is not necessary, you may write see attached. However, if you are not the primary carrier on your policy, please complete the insurace portions with the sponsors name and social security number for correct billing purposes.Please bring photo ID and insurance card to be copied, or complete this section entirely.

The next page if you are currently on a list of medication please attach that list and include your pharmacy information. PLEASE read the 24 hour cancellation policy at the bottom of the page and sign.

The third and fourth pages are for authorization to release your information to the insurance company for payment on your behalf. Please complete the top of this form with your name address phone etc, then where the insurance name is, write in your current insurers name. Lastly, print, sign and date the second page.

The last pages of this packet are our practice policies, please read over them carefully then sign the last page. If you have any additional questions please feel free to contact our office.

Thanks for choosing Compass Psychiatry.

COMPASS PSYCHIATRY

PATIENT INFORMATION

LAST NAME: ______________________FIRST NAME: ____________________MIDDLE INITIAL: _____

ADDRESS: ____

CITY: ____________________________ STATE: __________________________ ZIP CODE: _____________

HOME PHONE: _______________________ WK PHONE: ___________________CELL:________________

FAX: __________________________________ MARITAL STATUS: MARRIED___SINGLE___ WIDOW____

BIRTHDAY: ___________________ SEX: __________ SOCIAL SECURITY NO.________________________

EMPLOYER: _ _________________________________ EMAIL: _____________________________________

EMERGENCY CONTACT/GUARDIAN INFORMATION

NAME OF CONTACT OR GUARDIAN: ____

HOME PHONE: ___________________________CELL PHONE: _________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____

NAME OF INSURED: __________________________________ SS#: _________________________

CLAIMS ADDRESS: ____

PHONE: _____________________GROUP:_______________ POLICY#:________________________

SECONDARY INSURANCE: ____

NAME OF INSURED: _________________________________ SS#: ______________________________

CLAIMS ADDRESS: ____

PHONE: _______________________GROUP:____________________ POLICY: ____________________

MEDICATION INFORMATION

PRESENT MEDICATIONS: ____

____

MEDICATION ALLERGY: ____

____

PHARMACY: ____ PHONE: ____________________

AUTHORIZATION

- I HEARBY AUTHORIZE MEDICAL TREATMENT BY SVATHI REDDY.M.D, ROHIT KHANNA.M, D, JOANIE FUNK.LCSW-PHD, FIBIA DAVIDSON.LPC, ON THE ABOVE NAMED PATIENT.
- I AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO SVATHI REDDY.M.D, ROHIT KHANNA.M, D, JOANIE FUNK.LCSW-PHD, AND FIBIA DAVIDSON.LPC BY MY CONTRACTED INSURANCE COMPANY.
- I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL SERVICES RENDERED BY SVATHI REDDY.M.D,ROHIT KHANNA.M,D,JOANIE FUNK.LCSW-PHD,FIBIA DAVIDSON.LPC,INCLUDING CHARGES FOR MISSED OR CANCELED APPOINTMENTS WITHOUT 24 HOUR NOTICE AND PENALTIES /CHARGES FOR ANY OUTSIDE COLLECTION ASSISTANCE. **CHARGES FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE WILL BE AS FOLLOWS: $125 FOR AN INITIAL APPOINTMENT AND $50 FOR A MISSED FOLLOW UP APPOINTMENT WITH THE PSYCHIATRIST. FOR MISSED THERAPY APPOINTMENTS WITH ANY CLINICIAN, YOU WILL BE CHARGED $120.**
- I UNDERSTAND THAT I WILL BE CHARGED $35 FOR RETURNEDD CHECKS, THAT IF THE CHECK WAS RETURNED DUE TO BANK ERROR IT WILL BE MY RESPONSIBILITY TO GET THE FEE FROM MY BANK. I ALSO UNDERSTAND SVATHI REDDY.M.D, ROHIT KHANNA.M,D,JOANIE FUNK.LCSW-PHD,FIBIA DAVIDSON.LPC, ARE PENALIZED BY THEIR BANK WHEN CHECKS ARE RETURNED.
- I UNDERSTAND THE PROVIDER IS NOT RESPONSIBLE FOR ANY FINAL DECISIONS OF NON-PAYMENT BY MY INSURANCE COMPANY AND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL PAYMENTS DUE.
- I HEARBY AUTHORIZE THE RELEASE OF INFORMATION TO ANY DOCTOR WHO REFERRED ME FOR EVALUATION OR TREATMENT BY SVATHI REDDY.M.D,ROHIT KHANNA.M,D,JOANIE FUNK.LCSW-PHD,FIBIA DAVIDSON.LPC.
- I UNDERSTAND THAT PAST DUE BALANCES (OVER 30 DAYS) WILL ACCRUE CHARGES AT THE RATE OF 1.5% INTREST PER MONTH.

I HAVE READ AND REVIEWED THE POLICES AND PROCEDURES FOR THE OFFICE AND MY SIGNATURE BELOW INDICATES THAT I ACCEPT THEM.

PATIENT/ GUARDIAN
SIGNATURE: ____ DATE: ________________

COMPASS PSYCHIATRY, LLC

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby understand the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan of health care provider. The released information may no longer be protected by federal privacy regulations.

I authorize Svathi reddy M.D. Rohit Khanna M.D Joan R Funk PHD. Fibia Davidson, LPC ("The Practice") to disclose the following information from the medical records of:

Patient Name: ____ Date of Birth: ____________________________

Address: ____

Telephone: ____ Patient Number: __________________________________

Covering Period(s) of healthcare:

From _______ to _________
From _______ to _________

Information to be disclosed Select from the following (Check as many as apply):

Assessment
Diagnosis
Psychosocial Evaluation
Psychiatric Evaluation
Treatment Plan or Summary
Current Treatment Update
Medication Management Information
Other (Please Specify) Insurance Name: ____

Primary Physician: ____

Previous Psychiatrist and or Therapist: ____

This information is to be disclosed to the following individual or entity for the purpose of:

____

____

Name: ____ Relationship: ____________________________________

Address: ____

Telephone:___________________________________

The patient or representative must read and initial the following statement:

a. I understand that unless earlier revoked, this authorization will expire on __/___/______ or on the happenings of____ Initial: __________
b. I understand that I may revoke this authorization at any time by notifying the Practice in writing, if I do it won't have any effect on any actions the Practice took before it received the revocation. Initial: _________________
c. I understand that the practice cannot make me sign this authorization as a condition to receive treatment from the practice except:
   (i) When the practice provides me with research-related treatment; or
   (ii) When the practice provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
   Initials: __________

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form **MUST** be completed before signing)

____

Signature of Patient or Representative

____

Date

____

Print Name

____

Relationship of Representative to Patient

Please describe the representative's authority to act on behalf of the Patient:

____

____

You May Refuse To Sign This Authorization

Compass Psychiatry Practice Policies

At Compass Psychiatry we are committed to providing exceptional mental health services. The following information is provided to acquaint you with our policies and procedures. Please read through to the end carefully, print all pages if at all possible and sign at the bottom. Bring the signed forms to your initial appointment. This will aid us in saving time and best serving your needs.

Confidentiality

Your records are referred to as Private Health Information (PHI). PHI is confidential and protected by state and federal laws. We will not release your information to anyone without prior written consent from you or your legal guardian. You must sign a release of information for your insurance company if you are using medical insurance for services. Usually, the information we release to insurance companies includes dates of service, diagnosis, charges, major symptomology and our treatment recommendations. Records are not released directly to patients (Georgia Code 31-33-2). We do provide medical records to other physicians or attorneys with a signed release of information from you or your legal guardian. However, we are required by federal HIPAA rules to waive a patient's confidentiality in the event of: The patient's safety is potentially at risk or the safety of another individual is in jeopardy. Suspected abuse of a minor, elderly person or disabled person. In these situations, we are legally bound to report the suspected abuse or safety issue to the appropriate agency.

Appointments

Please call our office in Marietta at (770) 426-9929 or in Ellijay at (706) 635-4703 to schedule an appointment. Our capable staff will be happy to answer any questions about scheduling, insurance issues/coverage, fees or any other concern you may have. Please arrive at least 15 minutes early for your initial appointment.

Cancellation

WE REQUIRE 24 HOURS CANCELLATION NOTICE for all appointments missed for any reason. Without 24 hours cancellation, you will be charged $125 for an initial appointment and $50 for a missed follow up appointment with the psychiatrist. For missed therapy appointments any clinician, you will be charged $120 for all missed appointments. As the appointment time has been scheduled for you and as we are disallowed by law to bill the insurance company for missed appointments, you are responsible in full for this payment. As a courtesy, we make every effort to provide reminder calls for appointments but regardless of whether you have received a reminder call, you are responsible for your appointment. We understand that many circumstances make rescheduling of appointments necessary and our staff is happy to help reschedule your appointment with a minimum of 24 hours' notice without any charge being applied. This time allows another patient the chance to utilize the appointment time.

Fees

For your convenience, we accept most major insurance or self-pay for our services. You may enquire by calling our office whether your insurance is accepted and which providers are in network for your particular insurance

plan. Payment will be collected at the time of service. For your convenience we accept cash, personal check as well as Visa and Master Card credit and debit cards. Unpaid balances will accrue a 3% interest charge after 60 days of nonpayment. After 90 days of nonpayment, we will be forced to refer these bills to a private collection service. To avoid this situation, we encourage you to pay your balance at the time of service or to speak with our office manager, Marisa Botero, to arrange a suitable payment plan. We do not file claims for insurance companies we are not providers for. However, we are happy to provide a super bill for you to submit directly to your insurance company to receive out of network reimbursement for our services. If you are using insurance to cover your services, we are pleased to bill the insurance carrier if we have a current, valid insurance card on file and if we accept assignment from the insurance company. It is the patient's responsibility to ensure the clinician you are seeing is in network for your insurance and whether you have mental health coverage that will cover our services. Our office manager may also be able to assist you with this but it is ultimately the patient's responsibility.

Insurances Accepted

(Check with office staff on which clinicians accept your particular insurance)

Medicare, Aetna, Blue Cross Blue Shield, United Healthcare, Cigna, Humana, PHCS Multiplan, Optum, Tricare, Magellan, Principal, Value Options, Life synch.

Forms and Letters

There will be a fee assessed for any forms, letters, or records requested by the patient. Included in this list are disability forms, FMLA forms, Medical Record Requests, Employee Forms, Letters and Reports. The fee will be based on the time and work involved. You are responsible for these fees as they are not covered by insurance. Initial records to referring physician or PCP are without charge for the first 10 pages.

Prescriptions

We will provide prescriptions at the time of your appointment. Refills of prescriptions will not be mailed or called in for missed appointments. We are happy to reschedule you to the earliest available date. Please do ensure that you will not run out of your prescription prior to your scheduled appointment. If a prescription must be called in or mailed for a missed appointment, a $25 fee will be applied to your account.

After hours coverage

We do provide a 24 hour answering service for emergencies after office hours. Any call deemed non emergent will be returned in a timely manner during regular business hours.

BY SIGNING BELOW YOU ARE INDICATING YOU HAVE READ AND REVIEWED OUR OFFICE POLICIES AND AGREE WITH THEM.

________________________________ ________________________

Patient Signature Date

________________________________ ________________________

Signature of Legal Guardian or Parent of Minor
Date