PREMIER HEALTH

3651 Mars Hill Rd Suite 3400
Watkinsville Ga 30677
P.678-726-2227 F. 706-203-4640

PATIENT & INSURANCE INFORMATION

LEGAL NAME: _____ _____ **DOB:** _____
SEX: _____ **WEIGHT:**_____ **HEIGHT:** _____ **SSN:** _____
MARITAL STATUS: _____ **EMPLOYER:** _____
LANGUAGE: _____ **RACE/ETHNICITY:** _____ **RELIGION:** _____
ADDRESS:_____
HOME PHONE: _____ **MOBILE** _____ **OTHER** _____
EMAIL: _____ **ADVANCE DIRECTIVE:** ☐ **YES** ☐ **NO**
PCP: _____ **OTHER PROVIDERS** _____

PRIMARY INSURANCE: _____ **POLICY:** _____
PRIMARY INSURED: _____ **DOB:**_____ **SSN:**_____
SECONDARY INSURANCE: _____ **POLICY:** _____
PRIMARY INSURED: _____ **DOB:**_____ **SSN:**_____

PERSON RESPONSIBLE FOR PAYMENT, IF OTHER THAN PATIENT:

NAME: _____ **DOB:** _____ **RELATIONSHIP:** _____
ADDRESS:_____ **PHONE:** _____

CONSENT TO TREATMENT

I give permission to Premier Health to provide treatment. I understand I have the right to discuss all treatments with my clinician. I understand I have the right to refuse any procedure or treatment.

PATIENT RIGHTS AND RESPONSIBILITIES

Confidentiality is a privilege protected by law and by the ethics rules of the counseling profession that allows for private discussion of issues that concern you, in order to enable full and comprehensive treatment. Exceptions include: • Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself or others and compulsion by court order or lawful subpoena. • Additionally, we are required by law to report knowledge of any form of child neglect or abuse. We may also refer you to other providers that may better suit your needs. We have the right to a safe environment in which to provide services to our patients and our practice staff. Verbal/behavioral threats/acts will not be tolerated and you will be subject to dismissal from services and criminal charges.Informed Consent refers to your right to an explanation of your condition and treatment that you can understand. You have a right to participate in the planning of your treatment, refuse treatment and file complaints or compliments. Treatment often involves addressing concerns that are distressing and is best done in consultation with your provider. Respect and Non-Discrimination are part of your treatment regardless. Telephone Consultations refer to the occasional need to consult briefly by phone. For these necessary and brief consultations, there is no charge. However, if you desire further assistance, we can either schedule an office appointment or more extensive telemedicine phone consultation, the fees for which are not routinely covered by insurance plans.

We value our patients and the time for office visits has been reserved especially for you. We expect our patients to place the same value on our services and time. Our Cancellation Policy requires a 24-hour notice for canceling or rescheduling appointments. Missed appointments or late cancellations are subject to a minimum $50 fee up to the FULL FEE for anticipated services and can not be billed to insurance. THE OFFICE CANNOT BE HELD RESPONSIBLE FOR APPOINTMENT REMINDERS. Note that you can leave a message with the answering service after business hours. Continued failure to cancel appointments within 24-hours will result in termination of services and dismissal as a patient from our practice. Fee Payment is due at time of service unless other arrangements have been made. It is the patient's responsibility to notify the receptionist of any change in address, phone number or insurance. We appreciate the opportunity to serve your behavioral health needs. Please assist us in providing a more efficient service to you by contacting your insurance carrier to understand the extent of and limitations on your benefits and to obtain required authorization. We also request that when you attend your session you be prepared to provide the co-pay and/or deductible determined by your carrier. Failure to obtain proper authorization may unfortunately result in additional charges to you.

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.
- eVirtualcare, LLC, MedBill MD, LLC, Avenue One Medical Billing, LLC, and Medconverge are affiliated organizations to “Premier Health & Performance, LLC”; whose names may appear on invoices.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

ASSIGNMENT OF INSURANCE BENEFITS

I understand that, as a courtesy, Premier Health can file for insurance benefits to pay for the care I receive. I understand that Premier Health will have to send my medical record information to my insurance company. I must pay for the cost of these services if my insurance does not pay or I do not have insurance. In consideration of medical services rendered by Premier Health, to the extent permitted by law, I hereby irrevocably assign, transfer and set over to Premier Health all of my rights, title and interest to medical reimbursement, including, but not limited to the right to designate a beneficiary, add dependent eligibility and have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate to other health benefit indemnification agreement, otherwise payable to me for those services rendered by Premier Health during the pendency of the claim for these services. Such irrevocable assignment and transfer shall be for the recovery on said policy (ies) of insurance, but shall not be construed to be an obligation of Premier Health to pursue any such right of recovery. I hereby authorize the insurance company (ies) or third party payer (s) providing coverage for services to pay directly to Premier Health all benefits due for services rendered. I further authorize the release of any medical information necessary to process these claims.

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HIPAA NOTICE OF PRIVACY PRACTICES

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Use and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required or permitted by law. Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your doctor may share your health information with a specialist, referring physician or therapist, or hospital staff that will assist in your treatment. Your protected health information may be provided to a physician or therapist to whom you have been referred or who is providing on-call coverage to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided to the staff of Premier Health, which manages the billing and records stored in our office. Also, for example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare. Healthcare Operations: We may use or disclose as-needed, your protected health information in order to support the business activities of your physician's or therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, outside storage of medical records, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. Sharing Your Health Information: There are situations when we are permitted or required to disclose health information without your authorization. These situations are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities such as investigations, licensing, audits and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates; for organ and tissue donation; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for worker's compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; and disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Except as required by law, all other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. These requests must be in writing. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Fees may apply. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our staff. Signature below is acknowledgment that you have received, read and understand this Notice of our Privacy Practices:

PRINT NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

If you want to enable Premier Health to exchange information and /or records regarding you and/or your dependents, you must complete this form. Please make sure you complete this form in its entirety to ensure that we are fully informed of how and with whom you consent to the sharing of your protected health information. This release authorized the sharing of protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable Georgia law, for the purposes specified below. **This release applies to the following individual (yourself or your dependent, as applicable) (the "Patient"):**

PRINT NAME: _____ **DOB**_____

The scope of this release is as follows (check all that apply):

☐ To enable Premier Health to share the Patient's records with the following:
Name (person or entity): _____
Address: _____
Telephone:_____

☐ To enable the following person or entity to share the Patient's records with Premier Health:
Name (person or entity): _____
Address: _____
Telephone:_____

The purpose of this release is (check one):

☐ _____ (description of purpose)

☐ Personal request (no specific reason identified)

This release includes all of the Patient's records and other protected health information in the custody and control of the releasing party that may be released under applicable law, except that I do not authorize release of the following:

_____
_____
_____

Without limiting the foregoing, I understand that the following types of records/information will not be released unless I expressly so authorize by checking the box below:

☐ ALCOHOL/SUBSTANCE ABUSE RECORDS_____

☐ HIV TESTING OR TREATMENT

☐ AIDS INFORMATION

I give permission for a faxed or photocopied signature to serve as an original of this release. I understand that authorizing disclosure of health information as reflected in this release is entirely voluntary and that I need not sign this form in order to receive treatment. This authorization may be revoked by the individual signing it by providing a written, signed and dated request to withdraw the authorization. A proper revocation will be effective immediately except to the extent that action has already been taken or information has already been released to third parties pursuant to this or another proper release. The information released pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA/applicable law.

This release will expire on _____, or, if no date is specified, it will expire 90 days after the signature date below.

PRINT NAME: _____ **DOB**_____

SIGNATURE: _____ **DATE:** _____

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AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of controlled substance prescriptions may cause addiction and is only one part of the treatment. The goals of this medicine are: to improve my ability to work and function at home to help me as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following: I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine. I will not incready my medicine until I speak with my doctor or nurse. My Medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed. I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management) I will bring the pill bottles with any remaining pills of this medicine to each clinic visit. I agree to give a blood or urine sample, if asked, to test for drug use.

Refills: Refills will be made only during regular office hours. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I will not come for my refill until I am called by the nurse. I must keep track of my medications. No early or emergency refills may be made. I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name of my pharmacy is _____.

Prescriptions from Other Doctors: If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to appointments in the original bottle, even if there are no pills left.

Privacy: While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release.

Termination of Agreement: If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities: As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide care for you even if you are no longer getting controlled medicines from me.

PATIENT'S SIGNATURE: _____ **DATE:**_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

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PATIENT HISTORY

What issues or symptoms bring you to this practice? _____
Are the symptoms constant or intermittent? _____
List any previous psychiatric conditions you have been diagnosed with _____
_____
Name of previous psychiatrist and years seen _____
Name of current or previous counselor/therapist and years seen _____
_____
List of previous psychiatric hospitalizations with dates and reasons for admission_____
_____
Have you ever attempted suicide and if so, when and how? _____
_____
Have you ever received ECT (shock treatment)? _____
Have you ever had eating disorders (binge, purge, food restricting)? _____
_____
Have you ever had issues with cutting or self-mutilation? _____

MEDICAL INFORMATION

Have you ever been tested for HIV? _____ Results_____
Have you ever been tested for Hepatitis?_____ Results_____
Did you meet your developmental milestones? _____
Did your mother have exposure to drugs/traume while pregnant with you?_____
Are you Right/Left handed?_____

CURRENT MEDICATIONS AND DOSAGES (Including over-the-counter and herbal medications):
_____
_____
_____

MEDICATION ALLERGIES
_____
_____
Females only: Is there any chance you are currently pregnant? _____
Females only: Current birth control method used: _____

HOSPITALIZATIONS/ SURGERIES

DATE	WHERE	WHY

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BACKGROUND

Where were you born and raised? _____
Who raised you? _____
Have you lived in a group home or in foster care? _____
Number of siblings and their ages_____
What is your relationship status? _____
List previous relationships and their lengths? _____
Number of pregnancies? _____
Number of children and their ages? _____
What are your current living arrangements? _____
Highest education level you completed _____
Current employer/position _____
List your previous employment _____
Are you on Social Security Disability or have you filed for SSI? _____
Do you consider yourself a religious person? If Yes, what faith? _____
Have you ever been the victim of any form of abuse? _____
Have you ever had any legal problems? If so, what type/when? _____
Do you have access to firearms? _____
Describe any recent significant life changes or stressors _____
_____
Have you had any Military Service? _____ If and when, what branch?_____
Combat or Non-combat duty_____
Other information:

SUBSTANCE USE HISTORY

Are you a current or a former tobacco product user? _____ For how long? _____
Types of tobacco/vape products? _____
Have you ever abused or been dependent on any illicit drugs, prescription drugs or alcohol? _____
If yes, which drugs? _____
First used? _____
Last used? _____
Highest amount used? _____
Current amount used? _____
History of rehab/detox _____
Previous social/legal consequences to substance abuse _____
Other information: