**Dr. Wanda D. Hugget**

**Practice Policies**

**FEE SCHEDULE:**

$180 – 50 minute psychotherapy $360 – 2 hour initial intake appointment

$90 – 30 minute phone or tele-psych appointment $250 – per hour for psychological assessment

**CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES**

\_\_\_\_ VISA \_\_\_\_ MasterCard

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name as it appears on card

\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Credit / Debit Card Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Exp. Date

I/we authorize Dr. Hugget to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as “Dr. Wanda Hugget.” I will notify Dr. Hugget in writing if I no longer want my credit / debit card billed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of cardholder Date

**Credit Card Payment for Late Cancellation or No-Show**

I authorize Dr. Hugget to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of cardholder Date

**GUARANTOR INFORMATION:** *(complete only if the patient is NOT paying for the bill)*

Name of party responsible for bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\ \_\_\_\_\_\_\_\_\_\_\_ \ \_\_\_\_\_\_\_\_

Guarantor-Financial Responsibility Agreement: I, the undersigned, agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of cardholder Date

**BLUE CROSS BLUE SHIELD SUBSCIBERS (ONLY)**

|  |
| --- |
| Subscribers Birthday Subscribers Name Subscribers Employer |
| Subscribers Social Security # aDDRESS (IF DIFFERENT FROM cLIENT) |
| Insurance Company Patient’s Relationship to Subscriber List C0-Insurance |
| Group # Contract ID# Coypayment |

**PROVIDER: Wanda D. Hugget, PhD.**

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO PAY *PROVIDER* FOR SERVICES:**

AUTHORIZATION FOR RELEASE OF INFORMATION TO PROVIDER OF SERVICES:

I hereby authorize payment directly to Wanda D. Hugget Ph.D. of any and all benefits for charges for examination and /or treatment received by me or my dependent (s).

I hereby authorize benefit payers to release any and all information requested regarding such benefits and benefits payment to Wanda D. Hugget, Ph.D.

I hereby authorize Wanda D. Hugget, PhD., to release medical and other treatment information as may be required to obtain certain benefits for charges for services received to my dependant(s) or myself.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

**OFFICE HOURS:**

Office hours are by appointment only. Your doctor will let you know if she is in the position to offer treatment services beyond the first appointment.

**Emergencies/After Hours:**

Emergency psychiatric care is available 24 hours a day. During normal business hours, the receptionist will facilitate setting up an emergency appointment. If it is outside of normal business hours, call Dr. Hugget’s after hours number [248-872-5227](tel:1-888-836-2727). Leave a message for Dr. Hugget with your name, the patient’s name (if different), the best contact number at that time, and the emergency issue. Dr. Hugget will be notified and return your call as soon as possible. If you cannot wait, emergency psychiatric help is available through the Georgia Crisis and Access Line 24/7 at 1-800-715-4225 or you should call 911.

**SCHEDULING APPOINTMENTS:**

Please call the office during normal business hours to schedule an appointment. Generally, subsequent follow-up appointments will be scheduled with Dr. Hugget at the close of appointments if possible.

**PAYMENT POLICY:**

All new patients will need to pay the initial evaluation fee in full at the time services are rendered. Generally, fees are due at the time of service unless other arrangements have been made. Dr. Hugget’s private practice currently contracts with Blue Cross Blue Shield. For all other insurances, please check with your insurance company as to whether or not you would qualify for out-of-network benefits. If so, Dr. Hugget can fill out the necessary forms and your insurance company will reimburse you directly. Dr. Hugget accepts credit and debit cards as a convenience (see above) as well as checks.

Finally, all charges that are past due over 90 days may be sent to a collection agency unless arrangements have been made with your physician. We encourage patients to be aware of the charges that are being incurred.

**APPOINTMENT CHANGES/CANCELLATIONS:**

If an appointment is canceled with at least one business day’s notice, the patient/guarantor will not be penalized. A first-time cancellation within one business day of the scheduled appointment will not be penalized.

A second cancellation within one business day of the scheduled appointment will result in a fee equivalent to half the amount of the normal visit rate.

A third cancellation within one business day of the scheduled appointment will result in a fee of the full normal visit rate.

Exceptions will be dealt with on a case-by-case basis and are at the discretion of Dr. Hugget

If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.

**ELECTRONIC MAIL (EMAIL) and Skype/VSEE POLICY**

By agreeing to communicate via email or internet, you are assuming a certain degree of risk of breach of privacy. Dr. Hugget cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception.

Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature. Additionally, your doctor will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart.

To protect your privacy, be prudent in how you store treatment-related emails. Make sure they are protected from unauthorized access by using and guarding your passwords. Consider deleting any emails that you do not want others to see, followed by emptying your trash or recycle bins. Be aware that emails sent from a workplace computer are the property of the employer. Never send emails of an urgent or emergent nature. Your doctor will make an effort to check email regularly; however, call our office if you have not received a reply within 3 days.

**TELEPHONE POLICY:**

To provide quality care to her patients, Dr. Hugget likes to personally return calls to her patients. Routine phone calls made between the hours of 8:30 a.m. and 3:00 p.m. on weekdays will be returned within twenty-four hours. Routine calls received after 3:00 p.m. or on weekends may be returned the following business day. If it is an emergency, please convey this when making your call. Please be advised that this is for brief phone calls only.

For more extensive phone calls, please schedule a phone appointment. There will be a routine charge for these phone calls based on the time spent per call. Please note that most insurance companies will not reimburse for phone consultation fees.

**TERMINATION POLICY:**

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly.

**ACCEPTANCE OF POLICIES:**

Dr. Hugget is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the policies, understand, and agree with them.

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian if a Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF HEALTH INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

**Examples of Disclosures for Treatment, Payment and Health Operations**

*We will use your health information for treatment.* For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the treatment. In that way the physician will know how you are responding to treatment.

*We will use your health information for payment.* For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy your health record, amend your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For additional information about our health information practices or to report a problem, you may contact Dr. Hugget at 770-507-0005. A full copy of this notice is available upon request. If you believe your privacy rights have been violated, you can file a complaint with Dr. Hugget or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

My signature below indicated that I have read the notice of privacy practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_