

Dr. Jones' Practice Policies

PAYMENT POLICIES:

Generally, all initial evaluation fees are due at the time of service. Payments accepted include credit/debit cards and cash. Dr. Jones' private practice does not currently contract with any insurance carriers. Please check with your insurance company to determine if you would qualify for out-of-network benefits. If applicable, your physician can fill out the necessary forms requested by your insurance company. All past due charges over 90 days may be sent to a collection agency unless arrangements have been made with your physician.

FEES:

Service	Time (minutes)	Price
Intake:		
Medication Management	90	\$400
Psychotherapy	60	\$350
Follow up appointments:		
Psychotherapy	50	\$200
Medication Management	30	\$175
Phone Calls	15-25	\$50
	>25	\$100
Paperwork		\$50

OFFICE HOURS:

Office hours are by appointment only on Thursdays (9am-5pm) and Fridays (1pm-5pm) on days that are not recognized as federal holidays. All first appointments are considered a consultation only. Dr. Jones will notify you if she is in the position to offer treatment services beyond the first appointment.

EMERGENCIES/AFTER HOURS:

During normal business hours, our office manager will facilitate setting up appointments and respond to other administrative issues. Emergency psychiatric help is available through the **Georgia Crisis and Access Line 24/7 at 1-800-715-4225**. You can also call **988, 911**, or go to your nearest emergency department. For non-emergency psychiatric issues, call Dr. Jones 404-249-0520 ext 4. Leave a message with your name, nature of issue, phone number, and the best time to return your call.

SCHEDULING APPOINTMENTS:

Please call the office at 404-249-0520 during normal business hours to schedule an appointment. Appointments can also be scheduled via email with the office manager at officemanager@loriopsychgroup.com. Generally, follow-up appointments will be scheduled with Dr. Jones at the end of the current appointment if possible. Follow-up appointments can also be scheduled via email or phone (see above).

APPOINTMENT CHANGES/CANCELLATIONS:

If an appointment is canceled with at least one business days' notice, the patient/ will not be penalized.

A first-time cancellation within one business day of the scheduled appointment will not be penalized.

A second cancellation and subsequent cancellations within one business day of the scheduled appointment will result in a fee of half the normal visit rate. Exceptions will be determined at the discretion of the physician.

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

TELEPHONE POLICY:

Routine telephone calls will generally be returned by the next business day. Routine calls are considered brief phone calls up to fifteen minutes. For extensive phone calls (> 15 minutes) please schedule an appointment and see fees listed above. For issues that require a response prior to next business day, please alert our Office Manager of the urgency. For emergencies and crises please see above.

ELECTRONIC COMMUNICATION POLICY:

By agreeing to communicate via email or internet, you are assuming a certain degree of risk of breach of privacy. Dr. Jones 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. Call our office if you have not received a reply within 2 business days.

MEDICATION REFILL POLICY:

Medication refills may be requested during weekday business hours and will be called into the pharmacy within one business day of the request. Requests can be made via telephone and email. Requests made after 4:00 p.m., weekends, or holidays will be recorded on the following business day.

When requesting a refill, please provide:

- Patient name
- Date of birth
- Name of medication requesting
- Dosage
- Pharmacy name and telephone number

If all information is not provided, it may result in a delay in your refill authorization. Prescriptions may only be called in for patients who are current patients and who maintain their regularly scheduled appointments. For your safety, medication refills will not be called in over the weekend except in emergencies.

RELEASE OF INFORMATION:

For the purpose of patient safety, every patient who is prescribed medication by Dr. Jones is required to sign a release of information that permits Dr. Jones to request the most recent history and physical, problem list, and medication list from any other medical practitioner who is prescribing the patient medication. The release will also allow Dr. Jones to provide that practitioner with the medications being prescribed by Dr. Jones.

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

Visa MasterCard Discovery American Express
 Card Number _____ - _____ - _____ - _____ Credit Debit

Exp. Date: _____ CVV: _____

Name as it appears on card: _____

Billing Address: _____ Apt/Unit _____

City: _____ State: _____ Zip Code _____

I authorize Dr. Jones/Jones Psychiatry, LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as "Jones Psychiatry, LLC"

CREDIT CARD PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize Jones Psychiatry, LLC 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. I will notify Dr. Jones in writing if I no longer want my credit / debit card billed.

Name of cardholder: _____

Signature of cardholder: _____

Date: _____

TERMINATION POLICIES:

Patients are under no obligation to continue services should they decide to terminate at any time. However, patients are encouraged to notify Dr. Jones in person for the decision to be discussed openly.

ACCEPTANCE OF POLICIES:

Dr. Jones 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 name: _____

Patient's signature: _____

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. Jones at 404-249-0520 ext 4. A full copy of this notice is available from Dr. Jones at www.loriopsychgroup.com. If you believe your privacy rights have been violated, you can file a complaint with Dr. Jones or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

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

Signature: _____ Date: _____