Sandy Plains Psychiatry
3225 Shallowford Road Bldg 1300
Marietta, GA 30062
678-575-7754
FAX: 678-560-7185

PATIENT & FAMILY INFORMATION:

Name:_____ Birthdate: _____ M_____ F_____
Home# _____ Cell# _____ Email_____
Address:_____
City:_____ State:_____ Zip:_____
School or Employer:_____
Parent/Guardian Name (if patient is a minor)_____
Pharmacy: _____

INSURANCE INFORMATION:

Insurance Company:_____

Mental Health Coverage:
Did you confirm your mental health coverage with your insurance? ____Y____N
Do you need Prior Authorization for visits? ____Y____N
Is your Mental Health covered under the same company? ____Y____N
If no, please provide the company name _____

Primary on Insurance:_____ DOB:_____
Relationship to Patient:_____ Employer:_____

Please Sign Both Disclosures

Authorization for Disclosure of Information

By signing below, I hereby consent for the Practice to use or disclose information about myself (or the person whom I have authority to sign for) that is protected under federal law, for the sole purposes of treatment, payment and healthcare operation.

Patient Signature X_____Date:_____
Or Parent/Guardian

Authorization for Guarantee of Payment

I authorize payment of medical benefits to Sandy Plains Pediatrics. I will be responsible for the FULL amount of the charges except those under Sandy Plains Pediatrics contractual arrangements with certain insurers.

Patient Signature X_____Date:_____
Or Parent/Guardian

Sandy Plains Psychiatry
Waiver For Mental Health Visits

I _____, agree and consent to participate in the behavioral care services offered and provided by, Sandy Plains Psychiatry. I agree to accept full responsibility and payment for any visits with Vincent Ho, MD, Sara Moore, APRN and Allison Gilley, APRN in the event that my insurance company does not cover the date of service, or the services rendered are not covered. If the patient is under 18 years of age, or unable to consent to treatment, I attest that I have legal custody of the stated named patient below and authorize consent for treatment and services.

Patient's Name:

_____

Responsible Party's Name:

_____

Relationship to Patient:

_____

Responsible Party's Signature:

_____

Date

Verification of eligibility and benefits does not guarantee that the visit will be covered.

Patient Name: _____ DOB _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, and if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, insurance purposes and routine healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, insurance purposes or healthcare operations (consultations with specialists or hospitalists)
- The practice reserves the right to change the privacy policy as allowed by law
- The practice as the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments: YES NO

May we leave a message on your voicemail/answering machine: YES NO

May we discuss your condition with any member of your family: YES NO

If YES, please name the members allowed:

_____

_____

PRINT NAME: _____

Circle one: PARENT LEGAL GUARDIAN PATIENT

SIGNATURE: _____ DATE: _____