SG Psychiatry Clinic

Welcome to SG Psychiatry Clinic. We are delighted and honored you have chosen us for psychiatric services.

Attached please find our patient registration form and contract. Kindly complete these forms. Mark “N/A” for “not applicable” items and bring the forms to your first visit. Also, bring your insurance card, government issued Identification (i.e. drivers license), and payment. You will receive a copy of the contract and all receipts. Feel free to discuss any questions you might have about our services with the doctor. As the medical director, I am available to address any questions or concerns you may have.

We do not offer emergency services. If you should have an emergency before your first appointment or between appointments, please go to the nearest emergency room or dial your emergency services (911).

We have two locations. Please make sure you know which location applies to you! You can find directions on the website by clicking the “Contact Us” link.

Again, welcome!

Sincerely,

Shailesh Gandhi M.D. P.C.
www.sgpsychiatry.com

DATE
____ / ____ / _____

PATIENT INFORMATION

LAST NAME___________________________ FIRST NAME_____________________________ MIDDLE INITIAL ____ GENDER M / F____

DATE OF BIRTH (MM/DD/YYYY)________________ **SSN #**_____________________ EMAIL____________________________________

HOME #_____________________________ CELL #______________________________ WORK #_______________________________

MAILING ADDRESS____ CITY____________________ STATE____ ZIP CODE_________

EMPLOYER____ POSITION____

IF CHILD, PARENT INFORMATION

MOTHER: LAST NAME____ FIRST NAME____

DATE OF BIRTH (MM/DD/YYYY)_______________ HOME # IF NOT SAME AS PATIENT____

EMPLOYER & POSITION____ WORK #_____________________________

FATHER: LAST NAME____ FIRST NAME____

DATE OF BIRTH (MM/DD/YYYY)_____________________________________ **SSN #**____

EMPLOYER & POSITION____ WORK #_____________________________

IF APPLICABLE, CIRCLE ONE: CHILD IS… ADOPTED / UNDER GUARDIAN CARE / UNDER FOSTER CARE

IF SO, GIVE NAME(S) OF PARENT(S) ____

INSURED PERSON (PERSON CARRYING INSURANCE POLICY)

LAST NAME___________________________ FIRST NAME_____________________________ MIDDLE INITIAL ____ GENDER M / F____

DATE OF BIRTH (MM/DD/YYYY)_____________________________________ **SSN #**____

HOME #_____________________________ CELL #______________________________ WORK #_______________________________

MAILING ADDRESS____ CITY____________________ STATE____ ZIP CODE_________

EMPLOYER____ POSITION____

INSURANCE COMPANY____ POLICY NUMBER_______________________________________

INSURANCE COMPANY TELEPHONE NUMBER (#)______________________________________

EFFECTIVE DATE OF INSURANCE POLICY____

I hereby assign, transfer, and set over to Shailesh Gandhi, M.D. P.C. (SGPC) all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. [This assignment ONLY applies to insurance plans with which Shailesh Gandhi M.D. P.C. has a signed participation agreement.]

X____

____

PRINTED NAME AND SIGNATURE OF PATIENT (PARENT IF PATIENT UNDER 18) TODAY'S DATE

CONTRACT AND CONSENT FOR EVALUATION/TREATMENT

In consideration for receiving medical, psychiatric, and/or psychological services (s), I/we agree to the following.

Patient Last Name___________________________________, First Name____

The patient/parent/responsible party is responsible for all fees. Unless you are a beneficiary of an insurance plan with which we are networked, fees are payable at the time of the visit. If, for any reason, your insurance company fails to pay any portion of the amounts we bill as a courtesy to you, you are responsible for the balance and will be billed accordingly. **Any co-pays and deductibles are due at the time of the visit. We will bill you later if necessary, and therefore, will charge and additional $20 for the visit to cover the administrative expense**. We charge $300 for the initial doctor's appointment. Fees for subsequent visits are dependent upon the service provided. Medication management appointments are $125 for the 20-mintue session.

Returned checks are assessed a $50 fee. You agree to pay your bill within 10 days of receipt. If payment is not received within 30 days, you account will be turned over to a collection agency. We have the option to pursue all lawful collections procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

A credit card is required as part of the contract for evaluation and treatment. This credit card will be charged for missed appointments and/or outstanding balances that are past due 30 days.

□ MasterCard
□ Visa
□ AMEX
□ Disco

Credit Card Number __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Expiry date ____________________ CVV Code ______________________

Signature ________________________________

Cancellations

Appointments made and not kept are fully billed to you at the appointment fee level (see above). Your insurance company will not reimburse for any portion of missed appointments. Cancellation notice must be 48 hours before your appointment and made by calling 770-277-7195 and leaving a message.

Insurance

Many insurance plans reimburse for at least some portion of our professional fees. Please direct questions about reimbursement amounts, eligibility, and timeliness to your insurance company or benefits office. We will provide you with a detailed superbill at each visit if requested. Requests to complete insurance paperwork, beyond the superbill, will accrue a minimum $35 fee.

Records

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or patient's parents) release of information form. Record are copied at $.20 per page plus postage and billed directly to you. Please allow two weeks for this request to be processed.

Letters

Letters and Disability forms are often requested by patients (or their parents) to be sent to schools, employers, etc. You will be charged a letter-writing fee for this service, minimum $35.

CONTRACT AND CONSENT FOR EVALUATION/TREATMENT

In consideration for receiving medical, psychiatric, and/or psychological services (s). I/we agree to the following.

Telephone Calls

Your calls are welcome and we will return them promptly. You may also send us an email message letting us know the best times and telephone numbers to reach you. There is no charge for brief calls. Calls lasting more than five minutes will be charged directly to you on a pro-rated basis, minimum $35. If you have an emergency, please call 911 or go to the nearest emergency room.

Prescriptions

To prevent error and to maintain Insurance and healthcare standards, we do not call in routine prescriptions to pharmacy. Patient must be seen in office for routine visits and prescriptions. We may call in one week supply of certain medications in Emergency situations to pharmacy. There will be $ 35 charge for the call in, billable to patient or guarantor.

HIPAA/ Privacy Act

Your signature below acknowledges that you have been provided a notice of your privacy rights per HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, the full text of which is available at www.hhs.gov/ocr/hipaa/. Your signature also acknowledges that you are aware of the qualifications of your doctors, their regulatory agencies to whom you may file a complaint, and general rules about confidentiality and appropriate professional behavior.

Practice Standards require that all Patients be seen at a minimum of 2 months

I have been informed of and have read the above information and agree to it. By signing this consent, I also agree for limited information, if necessary, to be shared with another clinician in order facilitate my/my child's treatment/evaluation.

______________________________	______________________________
Patient's Printed Name	Guarantors Printed Name
______________________________	______________________________
Patients or Guarantor's Signature	Today's Date

Relationship of Guarantor to Patient: ___Self ___Spouse ___Parent ___Grandparent ___Guardian ___Caretaker ___Other:___________________________