Patient Name:_____ Date:_____2

# ARPCC General Information

Welcome to the AR Psychiatric and Counseling Center. We are a private mental health facility located at Lowndes County on the North Oak Street, extension. We also have a satellite office in Tift County. Our staff consists of psychiatrist, licensed clinical social workers, and licensed clinical professional counselors. We treat all age groups and provide psychiatric evaluation and management; individual, family and couple therapy for children, adolescents, and adults; and substance abuse /addictions assessment and treatment. In addition we are the first provider in South Georgia to offer **Transcranial Magnetic Stimulation** therapy for depression.

We recognize that psychiatric disorders are painful conditions that involve many aspects of a person's life. Understanding these various aspects and addressing unique individual needs is very important for recovery. At ARPCC, we use a comprehensive approach for evaluation and every patient has an individual treatment plan to addresses these various aspects of care. We are glad that you took the first step in seeking the care for painful emotional issues. Now, you can expect the best professional efforts, respect, and quality of care from our team of service providers. A very important aspect of treatment is that you fully understand the risks and benefits of your care. We like to encourage you and your family to take an active part in your treatment process and let us know if you don't understand any part of it.

Please review the following information and initial after each section. One of the ARPCC staff or your provider will review it with you when it is completed.

**Initial Evaluation & Follow-up Medication Visits**

On your **First Visit:**

- A clinician will obtain a detailed medical and psychiatric history; taking up to 30-40 minutes.
- In a few cases, when the diagnosis is not clear from history, he may need additional testing before making treatment recommendations.
- The clinician then explains the diagnosis, treatment recommendations and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow up appointment. It is wise to schedule that appointment while in the office, if at all possible.

For follow-up **Medication Management Visits:**

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. The clinician will meet with you, obtain information regarding your response to the treatment plan.
- For your safety, medication changes are generally not made over the phone. However, if you feel you are having an adverse reaction, please call your primary contact person immediately.
- You will typically see the clinician for return visits.

- If you need **Psychotherapy:**
  The clinician will refer you to a therapist in our office, if possible, on your insurance plan.

_____I have read the above policy and understand it. Initials

Patient Name: Date: 3

**Effective 11/01/2011**

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Professional

**Payment of services is handled prior to your session.** Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule.

We accept cash, checks, Visa, MasterCard, Discover, American Express, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit or debit. There is a $30 returned check fee. We do not accept temporary or post-dated checks if you are a new patient.

We charge for missed/canceled appointment, *unless* canceled at least 24 hours in advance. Our policy is to charge $50.00 for missed/canceled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having 3 or more no shows or cancellation of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments. NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manger.

Due to the time involved for our medical providers and clerical staff, it is necessary to charge for ALL forms and letters. This is to be paid in advance and is not billed to your insurance. The cost for drafting letters and completing forms is $50.00 each.

If you choose this office will provide you with a completed receipt showing charges, payments, which you may file with your insurance company.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has Managing Conservatory privileges for the minor child.

## REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

**If there are any changes in your insurance coverage, you must notify our office 5 days prior to your next appointment or the visit will be self-pay or rescheduled.**

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is any estimate only. You are ultimately responsible for any and all balances on your account.

**Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our office Staff.**

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF AR PSYCHIATRIC & COUNSELING CENTER.**

**Signature** **Date**

**Dr. Anil K. Gupta, M. D.**

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT: ___

**___ ITEM 1 – FEMALE PATIENTS**
Initial If taking medication, I agree to notify ***Dr. Anil K. Gupta, M.D.*** in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risks/benefits of medication.

**____ ITEM 2 – ALCOHOL/DRUGS/HERBAL SUPPLEMENTS**
Initial It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify ***Dr. Anil K. Gupta, M.D.*** if this is a concern.

**____ ITEM 3 – MEDICATION REFILLS**
Initial Medication is prescribed to last until your next appointment. You will need to make an appointment and be seen when medication refills are required.

**____ ITEM 4 – LETTERS AND/OR FORMS**
Initial There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

**____ ITEM 5 – THERAPY SESSIONS**
Initial Therapy sessions are scheduled for 30 or 45 minutes. In order that you receive your entire session, please be prompt for you appointment.

**____ ITEM 6 – CONFIDENTIALITY**
Initial All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information.

**____ ITEM 7 – CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR APPOINTMENT**
Initial I hereby give consent for myself or the above named patient to be treated/tested by ***Dr. Anil K. Gupta, M.D.*** If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above named minor. If you are **18 years of age,** you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. A parent/guardian may not come in for an appointment without the patient. **The patient must be present at every visit. Patients under 18 years of age will only be seen with a parent or guardian present.**

**___ ITEM 8 – TERMINATION OF TREATMENT**
Initial Assault or verbally threatening behavior towards staff, other patients, or physical property of ***Dr. Anil K. Gupta, M.D.*** will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

**____ ITEM 9 – CANCELLATIONS**
Initial **Cancellations must be made 24 HOURS before your session.** Your session time is reserved for you and you will be charged a **$50.00 no-show fee** for late cancellations or missed appointments. **Our office policy allows three no-show fees before terminating services.**

**____ ITEM 10 – OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS**

Initial We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

**____ ITEM 11 – MANAGED CARE PLANS**

Initial This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification for the insurance company, any denied amounts would be due immediately, upon being notified by our office.

**____ ITEM 12 – ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION**

Initial I hereby authorize my insurance carrier to pay benefits directly to ***Dr. Anil K. Gupta, M.D.*** for services provided to myself or my insured dependent, realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to ***Dr. Anil K. Gupta, M.D.***

**____ ITEM 13 – EMERGENCY SERVICES**

Initial I agree to contact ***Dr. Anil K. Gupta, M.D.*** or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

**____ ITEM 14 – FINANCIAL POLICY**

Initial I acknowledge that I have read and understand the financial policies of this office.

**____ ITEM 15 – NOTICE OF PRIVACY PRACTICES**

Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office Effective 11/01/2011

**____ ITEM 16 – BILLING INQUIRY**

Initial If you have billing questions, we will be pleased to help you. Contact our billing office at 229-244-2030.

**Items 1–16, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patient.**

| | | |
|---|---|---|
| Patient Signature | Initials | Date |
| Parent/Guardian Signature | Initials | Date |

**PATIENTS RIGHTS AND RESPONSIBILITY STATEMENT**

*Patients have the right to:*

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Their treatment and other patient information are kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. That is regardless of cost or coverage by the patients benefit plan.
- Share in developing their plan.
- Information in a language that they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing care.
- Ask the provider about their work history and training.
- Give input about the members rights and responsibilities policy.
- Know about advocacy groups and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have Provider decisions about their care be made without regard to financial incentives.

*Statement of Patients Responsibilities*

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the provider and patient.
- Follow the agreed upon medication plan.
- Tell their providers and primary care physicians about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their providers as soon as they need to cancel their visits.
- Let the provider know when the treatment plan is not working for them.
- Let their provider know about their problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

*My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.*

_____ _____ _____

***Patients and Guarantors signature*** ***Date***

Please feel free to ask the office staff to explain anything you do not understand. You may also obtain a copy if you wish to do so.

Office Staff
AR Psychiatric & Counseling, LLC