**Dr. Ganielle E. Hooper’s Practice Policies-2019**

PROFESSIONAL SERVICES:

* Dr. Hooper’s practice operates under the company Axis Hope, LLC.
* Dr. Hooper’s private practice currently contracts with Aetna and United Health Care.
* All patients must pay the evaluation fee or the co-pay fee in full at the time services are rendered.
* Fees can be paid before the appointment through the website or PayPal, or can be made at the time of service through cash, check, or credit card.

PAYMENT FOR SERVICES:

* Payment and co-pays are due before appointment or at the time of service.
* Regardless of any insurance coverage, I am financially responsible for all charges generated for this patient.
* Unpaid balances over 30 days past due will carry a late fee of $35.
* Unpaid balances over 90 days past due may be referred to a collection agency.
* Axis Hope accepts credit and debit cards as a convenience, as well as checks and cash.

LATE CANCELLATION/NO-SHOW FEES:

* Appointments must be cancelled no later than 24 hours of scheduled appointment.
* All appointments cancelled within 24 hours of appointment or no-show will be charged a fee of $50.
* All no-show fees are due before next appointment can be scheduled.

FEE SCHEDULE:

$250 – 90 minute initial intake appointment

$100 – 30 minute follow-up appointment

$50 – 20 minute psychopharmacology phone/telepsych appointment

OFFICE HOURS:

* Office hours are by appointment only.
* Typically, Dr. Hooper is in the office 9am-5pm Monday and Friday and select Saturdays.
* Wednesdays and Thursdays are reserved for late clinic hours and close at 6pm.

SCHEDULING APPOINTMENTS:

Please call the office at 678-648-7888 during normal business hours to schedule an appointment. Appointments can also be scheduled via email at info@axishope.care.

EMAIL:

* Axis Hope cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception.
* Due to this vulnerability, we caution you against emailing anything of a very private nature.
* Never send emails of an urgent or emergent nature.

TELEPHONE POLICY:

* Routine voicemail messages left during business hours will be returned

 within one business day.

* Please be advised that this is for brief phone calls only.
* For more extensive phone calls (10 minutes or more), please schedule a phone appointment with Dr. Hooper at the above pre-determined fee.
* Please note that most insurance will not reimburse for phone consultation fees.

MEDICATION REFILL POLICY:

* Medication refills may be requested during weekday business hours and will be completed within two business days of the request.
* If all information about refill is not provided on voicemail, it may result in a delay in your refill authorization.
* The amount of medication that will be dispensed will be enough to last patient until next appointment.
* Prescriptions may only be called in for patients who are current patients and who maintain their regularly scheduled appointments.

MEDICAL RELEASES OF INFORMATION:

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

EMERGENCY INFORMATION:

If it is an urgent clinical issue that cannot wait until the next business day, dial the office and leave a message with your name, the patient’s name (if different), the best contact number at that time, and the urgent issue. Dr. Hooper will be notified and return your call as soon as possible.

For emergencies, please access emergency psychiatric help through:

* Georgia Crisis and Access Line 24/7 at 1-800-715-4225 or
* Suicide prevention Lifeline 24/7 at 1-800-273-8255 or
* 911 or local Emergency Department.

Patients/Parents are encouraged to ask any questions related to this document before signing.

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

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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