Axis Hope Practice Policies-2019

www.axishope.care
678-503-8629

PROFESSIONAL SERVICES:

- Dr. Ganielle Hooper's practice operates under the company Axis Hope, LLC.
  - Axis Hope, LLC was created to address the mental health needs of children and adolescents. We assess, diagnose, and treat mental illness through a comprehensive physical, mental and psychosocial exam. We also *develop treatment plans* and *prescribe medications* for symptom management.

PAYMENT FOR SERVICES:

- Payment is due *before* appointment.
- Axis Hope accepts credit and debit cards as a convenience, as well as cash and check.
- Fees can be paid through our website (or if cash or check, at time of service).
  - **To pay Online or with Paypal, go to**: axishope.care/payment and select appropriate option. (New Patient or Follow-Up)
  - **To pay with credit card**: Accept the *"Patient Portal"* request and input your information.
  - **Or make a check payable to**: Axis Hope, LLC

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:

$300 – 60 minute initial intake appointment
$150 – 30 minute follow-up appointment in the office
$100 – 20 minute phone/tele-psych appointment
$ 50 - No Show Fee

OFFICE HOURS:

- Office hours are by appointment only.
- Typically, Dr. Hooper is in the office 9am-4pm Monday thru Friday and one Saturday a month.
- Mondays are reserved for late clinic hours and close at 6pm.

SCHEDULING APPOINTMENTS:

Please call the office at 678-503-8629 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.
- For more extensive phone calls (10 minutes or more), please schedule a phone appointment with Dr. Hooper at the above pre-determined fee.

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: ____