Patient Agreement

Atlanta Adult & Forensic Psychiatry

Joseph Browning, M.D.
4401 Northside Parkway NW, Suite 245
Atlanta, GA 30327
(404) 913-6240 | (619) 931-2773 fax
joebrowning@josephbrowningmd.com
www.josephbrowningmd.com

POLICIES

All prospective new patients are required to review these policies and complete the Patient Agreement prior to scheduling an appointment. Appointment requests will not be scheduled without completion of the Agreement.

Office Hours:

Dr. Browning is available by appointment only. He is typically in the office on Tuesdays, Thursdays, and Fridays from 9:00 am to 4:00 pm. Because Dr. Browning also does forensic work that requires courtroom testimony or out-of-office evaluations, he may not always be in the office and is unavailable for drop-in visits without a scheduled appointment.

Initial Evaluation:

Dr. Browning conducts a thorough psychiatric evaluation during the initial session, which is typically scheduled for 60 minutes. This assessment focuses on determining the best treatment plan possible and is specific to each individual patient. It is important for this session to be as comprehensive as possible, and the completed Patient Agreement is required before the appointment can be scheduled. Additionally, collateral information (hospital records, family reports, etc.) is often necessary for a thorough evaluation. After the initial evaluation is complete, we will mutually determine whether Dr. Browning is the best fit for your individualized care. A treatment relationship does not exist until the evaluation is complete and Dr. Browning agrees to provide care.

Communication:

Once you have established care with Dr. Browning, you may call or email to communicate with him. He will make every effort to return your call or email communication promptly. Please do not delay in calling or sending an email if there is an issue of concern. While Dr. Browning uses HIPAA compliant email, he cannot guarantee that your email communication will not be intercepted by a third party "hacker" or unintended recipient. Email also becomes a part of your medical record. Please be careful about using email to transmit anything of a very private nature, and please do not email if you are in crisis.

Emergency and Crisis Services:

Dr. Browning cannot always guarantee immediate availability. If you are having a psychiatric emergency, please call 911 or go to the nearest emergency room. Once safety has been established, please then notify Dr. Browning. 24-hour emergency crisis services can also be obtained by dialing 988 or calling the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225.

Confidentiality:

Your confidentiality is protected by law and critical to mental health treatment. However, exceptions to confidentiality do exist, and some of those exceptions are required by law. Such examples include when you are a danger to yourself, a danger to others, when you are gravely disabled due to mental illness, if there is suspicion of child, elder, or dependent abuse, or in certain judicial proceedings. These situations can be rare, and we will make every effort to discuss the proceedings accordingly.

Fees:

Dr. Browning charges $500 for a 60-minute consultation that focuses on assessment and evaluation. If you and Dr. Browning agree to continue services beyond this initial evaluation, Dr. Browning charges $250 for 25-minute follow-up visits and $400 for a 45-minute therapy session (with or without medication management). Other professional services that require longer than 10 minutes of time are billed at $125 per 15-minute increment. This can include letter writing, telephone conversations, or preparation of treatment summaries. Dr. Browning does not write letters for emotional support animals.

Billing and Payments:

Dr. Browning accepts payment by cash, check, and all major credit and debit cards. Payment is due at the beginning of each appointment. Credit / debit card details are held securely by our payment processor and are not held directly in the office. Additional payment for other professional services (see above) will be agreed upon at the time of your request for these services. If your account is overdue for more than 30 days, you may incur a late fee equivalent to 3% per month of that outstanding balance. Unpaid bills may result in termination of treatment. We also reserve the right to use legal means to secure payment. This includes charging an on-file credit card, as well as utilizing a collections agency or a small claims court. In such cases, certain information like name, nature of services provided, clinical notes, and amount due may be required by these agencies. A $50 fee is charged for all returned checks.

Medication Refill Policy:

Prescriptions may only be refilled for active patients who maintain their regularly scheduled appointments. Medication refills will generally be sent to the pharmacy within two business days after the request is made. When requesting a refill, please provide:

Your date of birth
Name of medication requested
Medication dosage
Pharmacy complete address

Appointment Changes / Cancellations:

Patients will be charged for their full session for no-shows or cancellations less than one business day in advance. Both telephone and email are acceptable ways to notify of a cancellation. If Dr. Browning must cancel an appointment, he will let you know at the earliest possible time.

Insurance Reimbursement:
Dr. Browning does not accept private insurance. However, if your insurance company provides out-of-network benefits, Dr. Browning will provide an invoice / statement (often known as a "super bill") on request that contains the necessary information for you to make a claim that would be reimbursed directly to you. This information includes your name, your date of birth, your diagnosis, the date of service, and the services provided. Your signature below authorizes us to email you with a super bill that you can provide to your insurance company. Contact your insurance company to inquire about your specific out-of-network benefits.

Medicare / Medicaid:
Dr. Browning does not accept patients with Medicare or Medicaid in his private practice.

Telehealth:
Dr. Browning offers HIPAA compliant tele-psychiatry services to patients for whom this is appropriate. However, these appointments are available only to Georgia residents, and they are only available when the patient is in a safe, secure location (i.e. not driving a motor vehicle) with an adequate internet connection. For tele-psychiatry appointments, the above cancellation policy applies.

Discharge:
You may be discharged from the practice for violation of office policies. A patient must be seen a minimum of twice per year in order to remain a patient of Dr. Browning. Patients are under no obligation to continue services with Dr. Browning if they choose not to, and they may terminate care at any time. Please notify Dr. Browning if you choose to terminate care.

ACCEPTANCE OF POLICIES:
I have read the policies, understand them, and agree with them.

Patient's (or Guardian's) Signature:	
Print Name:	
Date:	

CLEAR FORM

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PATIENT INFORMATION AND CONSENT FOR TREATMENT

DEMOGRAPHIC INFORMATION:

Name: | Last | First | Middle |

Address: | Street |

| City | State | Zip |

Phone: | Alternate Phone: |

Are voice messages OK? Select | Are text messages OK? Select

Email:

DOB: | Month | Day | Year | Sex:

REASONS FOR SEEKING TREATMENT:

PERSONAL INFORMATION:

Employer: Phone:

Profession:

Emergency Contact: Phone:

Relationship to Patient:

Who referred you?

MEDICAL INFORMATION:

Medical Conditions:

Current Medications:

Allergies:

Primary Physician: Phone:

Primary Therapist: Phone:

PHARMACY INFORMATION:

Pharmacy:

Street Address

City | State | Zip

Pharmacy Phone:

Do you have Medicare or Medicaid? No

Have you recently had thoughts of harming yourself or others? Select

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the Patient Agreement which contains information on psychiatric services, communication, emergency and crisis services, confidentiality, fees, billing and payments, appointment changes and cancellations, insurance reimbursement and emailing of super bills, telehealth, discharge, and use and disclosure of protected health information. Your signature also indicates that you agree to abide by the policies in the Patient Agreement during your professional relationship with Atlanta Adult and Forensic Psychiatry, LLC, and that you agree to be treated by Atlanta Adult and Forensic Psychiatry, LLC.

Patient's (or Guardian's) Signature:

Print Name:

Date:

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PAYMENT INFORMATION

CREDIT / DEBIT CARD INFORMATION:

☐ VISA ☐ MasterCard ☐ AMEX ☐ Discover

Name as it Appears on Card | Billing Zip Code | CVV

Card Number | Exp: Month / Year

I authorize Atlanta Adult and Forensic Psychiatry, LLC, to bill the above credit / debit card for professional services as outlined in the Patient Contract. I will notify Atlanta Adult and Forensic Psychiatry, LLC, in writing if I no longer want my credit / debit card billed.

Signature of Cardholder | Date

CREDIT / DEBIT CARD PAYMENT FOR LATE CANCELLATION OR NO-SHOW:

I authorize Atlanta Adult and Forensic Psychiatry, LLC, to charge the above credit / debit card when I do not give advance notice for a late cancellation or no-show as per the Patient Agreement. I understand that if I do not want my credit / debit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature of Cardholder | Date

GUARANTOR INFORMATION:

Complete this section only if the patient is NOT paying for the bill.

Guarantor Name: | Last | First | Middle

Address: | Street

| City | State | Zip

Phone: | DOB: | Month | Day | Year

Email:

GUARANTOR AGREEMENT:

I, the undersigned, understand that payment for treatment does not entitle me to receive information about treatment unless authorized by the patient. However, I understand that regardless of any insurance coverage, am financially responsible for all charges generated for this patient. I have reviewed the Patient Agreement and understand that office policy requires payment at the time of service. I understand that unpaid bills may result in termination of treatment. I also understand that unpaid balances may be referred to a debt collection agency or small claims court, that my on-file credit card may be charged for services, that a $50 fee is charged for all returned checks, and that a late fee equivalent to 3% of the outstanding balance per month may be charged for bills overdue for more than 30 days.

Signature of Guarantor | Date

PATIENT AUTHORIZATION FOR COMMUNICATION WITH GUARANTOR:

I authorize Atlanta Adult and Forensic Psychiatry, LLC, to communicate with my guarantor to the extent necessary to obtain payment. This can include appointment dates, missed appointments, etc.

Signature of Patient | Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil rights by sending a letter to · 200 Independence Avenue, S.W., Washington, D.C. 20201 · calling 1-877-696- 6775 · or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your info unless you give us written permission:	• Marketing purposes. • Sale of your information. • Most sharing of psychotherapy notes.
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OTHER USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you. · Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. · Example: We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities. · Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: · Preventing disease · Helping with product recalls · Reporting adverse reactions to medications · Reporting suspected abuse, neglect, or domestic violence · Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: · For worker's compensation claims · For law enforcement purposes or with a law enforcement official · With health oversight agencies for activities authorized by law · For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applies to:

Atlanta Adult and Forensic Psychiatry, LLC
4401 Northside Parkway NW, Suite 245
Atlanta, GA 30327

My signature below indicates I have read the Notice of Privacy Practices.

Patient's (or Guardian's) Signature:	
Print Name:	
Date:	

Effective April 13, 2023

Atlanta Adult & Forensic Psychiatry

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have reviewed the Notice of Privacy Practices and Patient Agreement prior to signing this consent. Atlanta Adult and Forensic Psychiatry, LLC, reserves the right to revise its Notice of Privacy Practices and / or Patient Agreement at any time. A revised Notice of Privacy Practices or Patient Agreement may be obtained by forwarding a written request to:

Joseph Browning, M.D.
Atlanta Adult and Forensic Psychiatry, LLC
4401 Northside Parkway NW, Suite 245
Atlanta, GA 30327

With this consent, Atlanta Adult and Forensic Psychiatry, LLC, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in doing business, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Atlanta Adult and Forensic Psychiatry, LLC, may mail to my home or other alternative location any items that assist the practice in doing business, such as appointment reminder cards and patient statements.

With this consent, Atlanta Adult and Forensic Psychiatry, LLC, may email me any items that assist in doing business, such as appointment reminder cards and patient statements. I have the right to request that Atlanta Adult and Forensic Psychiatry, LLC, restrict how it uses or discloses my PHI to do business. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Atlanta Adult and Forensic Psychiatry, LLC, to use and disclose my PHI to do business. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlanta Adult and Forensic Psychiatry, LLC, may decline to provide treatment to me.

Patient's (or Guardian's) Signature:	
Print Name:	
Date:	