New Patient Registration Form

Patient information:

Today's Date: ______________________ **Email:** ______________________

Name: ______________________ **DOB:** ______________________

Mailing Address: ______________________ **Age:** ______________________

City, State, Zip: ______________________ **SSN:** ______________________

Phone: ______________________ **Marital Status: Married ( ) Single ( ) Other ( )**

In case of Emergency, Notify: ______________________ **Sex: Male ( ) Female ( )**

Phone: ______________________ **Referred by:** ______________________

Relationship to patient: ______________________ **Phone:** ______________________

Insurance Information

Primary Insurance: ______________________ **Secondary Insurance:** ______________________

ID Number: ______________________ **ID Number:** ______________________

Mailing Address: ______________________ **Mailing Address:** ______________________

City, State, Zip: ______________________ **City, State, Zip:** ______________________

Name/Policy Holder: ______________________ **Name/Policy Holder:** ______________________

SSN: ______________________ **SSN:** ______________________

DOB: ______________________ **DOB:** ______________________

Employment Information

Employer: ______________________ **Telephone:** ______________________

Mailing Address: ______________________ **City, State, Zip:** ______________________

Responsible Party Information

Name: ______________________

Mailing Address: ______________________

City, State, Zip: ______________________

DOB: ______________________

SSN: ______________________

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility

X ______________________
Responsible Party Signature

Phone: ______________________

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: ______________________ **Date:** ______________________

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: ______________________ **Date:** ______________________

Cancellation of Scheduled Appointments

I understand that if I have a serious emergency and I am unable to come to my appointment, I will contact the office as soon as possible. In other cases, if I fail to cancel my appointment 48 business hours in advance, I will be charged $90.00 for the missed appointment.

Signature: ______________________ **Date:** ______________________

Name: ______________________________
DOB: ___/___/______

Welcome to the
The Neuropsychiatric Clinic of Atlantis

The Neuropsychiatric Clinic of Atlantis' practice is primarily focused on modern-day, cutting edge neuropsychiatry, more-or-less, the treatment of disorders of the brain and central nervous system that may affect the patient's feelings, behavior, memory, etc. The initial assessment will consist of the patient completing the intake assessment packet so that the providers will have a better understanding of the patient's presenting problems and concerns and that they may review during and after in coordinating treatment with other physicians, licensed professional counselors, psychologists, etc.

Dr. Warner is a board certified psychiatrist and has been trained and is familiar with all modalities of psychotherapy (talk therapy); however, he is NOT focused on extensive psychotherapy. Dr. Warner works closely with excellent psychotherapists in the area that might provide that type of treatment if he deems it necessary that the patient is in need of more in-depth exploration of psychological issues, i.e. marital conflicts, childhood abuse, personality disorders, etc. He is genuinely concerned about the patient's wellbeing but chooses to focus on the biological, neurological, and medical aspects of psychiatric illness.

The initial phase (acute phase) treatment shall be the initial assessment, weekly or biweekly follow-up to monitor clinical response to psychiatric medications and potential side effects, additional laboratory workup, neuroimaging (MRI, CT) and/or EEG, consultations with other physicians and/or referral to psychotherapist, as mentioned above. Follow-up visits will usually be 20 minutes or possibly longer depending upon the severity of the case.

The next phase (treatment phase) shall consist of monthly appointments with minor adjustments to medications, compliance issues, etc. As these appointments tend to be shorter, Dr. Warner encourages patients to schedule an appointment sooner if complications arise before the next appointment in order to schedule more time to address these issues.

The maintenance phase is typically after the patient is in full remission or baseline functioning that can be reasonably expected depending upon the severity (i.e. schizophrenia, dementia) of the illness. Maintenance treatment will likely be necessary for recurrent depression, bipolar depression, etc. As mentioned above, Dr. Warner encourages and expects the patient to call for a sooner and more extensive appointment if problems arise in between scheduled appointments.

We hope that you will be satisfied with your treatment at the clinic and with Dr. Warner's years of training, clinical experience, board certification and ongoing continued education. We feel confident that you will receive the best psychiatric care available.

____ ________________

Patient/Guardian Signature **Date**

____ ________________

Witness **Date**

The Neuropsychiatric Clinic of Atlantis, P.C

Medication and Office Policy

By initialing and signing this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible.

_____ 1. I am aware that the use of such medicine has certain risks if I stop taking them without notice or advising the physician.

_____ 2. I understand that the main treatment goal is to be compliant with my treatment and appointments. In consideration of that goal and the fact that I am being given medication to help me reach that goal.

_____ 3. I agree to tell my doctor about all medication and treatments that I am receiving at this time. **I will not abuse controlled substances/medications that I am given from my physician**

_____ 4. I understand the following refill policy:

   a. ***In order to get your medication you need to be compliant with your appointments***
   b. ***We do not do refills via fax***
   c. ***If you miss your appointments or no show and you are out of medication you will be allowed only 5days worth of medication and it is your responsibility to get a appointment as soon as possible for more medication.***
   d. ***Do not request refills with our answering service***

_____ 5. I agree to use the pharmacy that I have given the office for my medications. If I change pharmacies for any reason, I agree to notify the front office staff when I check in prior to seeing the physician.

_____ 6. I agree to **keep all scheduled appointments** at all times.

_____ 7. At each visit I may be asked to give a urine sample for the purpose for medication management, prior to seeing the physician we need a sample. We are unable to prescribe any medication until a sample is given.

_____ 8. I agree to handle all my prescribitons with care, providers **will not reissue another one if lost or misplaced.**

_____ 9. I will give the office 48 hour notice if I am unable to keep my schedule appointment ,we have a very high call volume of patients and each patient time is valuable. (**I am aware there is a $90 no show fee policy**).

_____ 10. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 11. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for him or herself.

_____ 12. I will notify the office of any hospitalization and follow-up with office for an appointment as soon as possible.

_____ 13. **I understand that if I fail to comply** with the office policy's it will cause for the provider to close my chart and I will have to find another provider in this agreement and on my prescription labels; if I obtain similar narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

Patient name: ______________________________

Patient/Guardian signature and date: ______________________________

Witness signature and date: ______________________________

The Neuropsychiatric Clinic of Atlantis, P.C

Our providers are strictly treatment and medication management providers. They will only focus on these issues only.

We will not handle the following cases/no exceptions:

- **Social Security/Disability Claims (only send medical records to them with a request from facility.)**
- **Legal cases (Custody, Divorce, Probation, Civil, or Criminal Cases, etc.)**
- **Workers' Compensation**
- **No lawsuits of any kind**
- **Leave of Absence or FMLA forms will not be signed on first initial visit**

This includes filling out any forms, writing any letters, or speaking to any insurance companies, lawyers, employers, miscellaneous facilities, etc.

Failure to inform our office of any of the above pending or intended future claims will result in immediate dismissal by our office.

There is a **$15.00 charge** for any medication that requires a **prior authorization**. This fee is the responsibility of the patient. Patients have the option of providing our office with a copy of their insurance formulary list to avoid this extra expense. Insurance restrictions on medications require an enormous amount of extra time and paper work for the nurse and physicians. If insurance was to change, you are responsible for bringing the new insurance formulary for the provider.

Please be advised that we can only fill certain forms out for patients and there is a $75.00 fee. Also you need to advise office about the forms so we can make appointments accurately to have enough time to get the forms done. **WE DO NOT FILL OUT ANY FORMS ON THE FIRST VISIT.**

We take pride in our patient care here at the Neuropsychiatric Clinic of Atlantis. We want to continue the best possible care available to our patients. We cannot take the time to render quality care if our provider is consumed with an enormous amount of paperwork or telephone calls regarding any of the cases listed above.

Thank you for your cooperation and understanding in this matter.

________________________________ ________________

Patient/ Guardian Signature Date

________________________________ ________________

Witness Date

The Neuropsychiatric Clinic of Atlantis, P.C

Missed Appointment Policy

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled **48 hours** in advance. Our providers want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Due to frequent missed appointments and or/cancelling appointments within 48 hours. If you frequently reschedule or no show within 6 schedule appointments interval, it will result in consideration of closure to your chart. **If you miss a scheduled appointment you will be responsible to pay $90.00 fee.** This fee is **not covered by insurance** and is the patient's responsibility. This fee will need to be paid before we make your next appointment.

The 48-hour notice does not include weekends or holidays. Traffic issues are **NOT** acceptable. Also, **Reminder calls are a COURTESY provided by our staff and will not be a justifiable reason for missing an appointment.** You are responsible for keeping up with your appointment date/time.

This is a very busy practice and time is valuable. Should you have a problem or complaint, please feel free to contact our office during business hours.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

By signing this agreement, you understand the importance of scheduling an appointment upon leaving the office.

Patient/Guardian Signature:______________________________ **Date:**______________

Witness:____________________________________ **Date:**______________

Due to increased volume of Patients needing appointments, Repeat Cancellations for any reason will result in possible closure of your case. When you cancel your appointment your next scheduled appointment may not be for several months, other than* ***URGENT* *emergency work-in appointments.*

The Neuropsychiatric Clinic of Atlantis, P.C

CONTROLLED SUBSTANCE POLICY:

To All Patients:

- We *will not* refill prescriptions early or replace lost prescriptions. If prescriptions have been stolen, then your physician will require an official police report describing the theft. A claim of theft will be allowed only *one time*.
- You agree **NOT** to seek the prescription of opioid medications, stimulants or any other controlled prescription drugs from any other physician without the *knowledge* and *consent* of your provider.
- Prescription refills will be authorized only during regular office hours. It is understood that patients shall not call the answering service after hours requesting such otherwise as detailed in the *prescription refill policy*.
- You agree to keep all scheduled appointments with your provider. Two consecutive missed, rescheduled, and/or cancelled appointments may lead to dismissal from the practice at the discretion of your provider as detailed in the *notice of appointment scheduling policy*.
- You agree to provide regular and/or random urine specimens for medication monitoring purposes. Screens will be obtained at regular appointments and a random basis typically 4 times per year or more at the discretion of our providers. Positive tests for any illegal substances or prescription drugs not being prescribed or approved otherwise by our providers *may likely* result in dismissal from the practice.
- You understand that if your insurance carrier does not cover the in-house urinary testing charges you will be responsible for a $25.00 fee to cover this service.
- It shall be understood to abstain from alcohol consumption while taking controlled substances. Clinic shall not assume responsibility for patient driving or operating heavy machinery while taking medications prescribed by our providers.
- You agree to comply fully with all aspects of your treatment program, including this written agreement. Failure to comply may lead to a discontinuation of your medication and treatment by clinic(s) providers. It is expected that patient will notify our office of the use of any new medications including over the counter medications that may lead to false positive results and/or interfere with treatment otherwise.
- We understand that emergencies may occur requiring treatment with medications by other providers outside of business hours and under some circumstances, exceptions to these guidelines may be made by your provider, and that such circumstances will be considered on an individual basis.

Thank you for your cooperation and understanding in this matter.

______________________________ ______________
Patient/Guardian Signature Date

______________________________ ______________
Witness Date

EFFECTIVE DATE APRIL 1, 2005

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 CAREFULLY

HOW WE MAY USE AND DICLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may disclose your record to an insurance company so that we may get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside of the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your case.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the notices that are currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could included disclosure to, or for, coroners, medical examiners and funeral directors ; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and workers' compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restriction. You have eth right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practices waiting room.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the privacy officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Others uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

The Neuropsychiatric Clinic of Atlantis, P.C
Randy T. Warner, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received a copy of the Neuropsychiatric Clinic of Atlantis' Notice of Privacy Practices (HIPPA).

____ ____________
Patient/Guardian signature **Date**

____ ____________
Witness **Date**

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, ______________________________ ____/____/______
(Patient Name – Please Print) (Patient Date of Birth - MM/DD/YYYY)

authorize **NPC Of Atlantis, P.C.** , to release protected health information related to my evaluation and treatment to:
(Provider Name – Please Print)

PCP Name: ______________________________ **PCP Phone:** ______________________

PCP Address:
______________ ______________ ______ ______________
(Street) (City) (State) (Zip Code)

Patient Rights

- You can resend(with written signature), this authorization (permission to use or disclose information) any time by contacting:

____

- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire, unless another date is specified. I have read and understand the above information

________ ** I DO NOT want any medical information disclosed to my PCP.**

______________ ______________ ______________ ______________
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: ______________________________

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(1)____

(Name) (Date of Birth)

____

(Street Address) (City, State, Zip Code)

I authorized the use and /or release of my protected health information as described in Section 4 below. I understand this authorization is voluntary and is made to confirm my instruction.

(2) ***Authorization To Release From:***

____
Name

____
Street Address

____
City, State, Zip

Fax #:__________________________

(3) ***Release Protected Health Information To:***

____
Name

____
Street Address

____
City, State, Zip

Fax #:__________________________

(4) Health Information to Be Released For the Following Dates:____

Include:

___ **All Medical Records**
___ **Billing Records**
___ **Treatment Plan**
___ **Evaluation Reports**
___ **Lab Reports/Radiology Reports**
___ **Medication List / Diagnostic Material**
___ **Progress Notes**

(5) Expiration: This authorization becomes effective _____/______/_____ and may be revoked by me in writing at any time except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates one (1) year from the effective date. This will expire one (1) year from the date of my signature below. I further understand that if I am under a criminal justice system referral this cannot be revoked by me until there has been a formal and effective termination or revocation of my release from probation or parole or other proceeding under which I was mandated for treatment.

(6) Understanding and Signature: I further understand that the information authorized by this Release will be released to the authorized receipt only for the purpose noted above. I understand that the information used or released as a result of this authorization may no longer be protected by the federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

______________________________ ____________________
Patient Signature or Legal Guardian ***Date***

______________________________ ____________________
Witness ***Date***

THE NEUROPSYCHIATRIC CLINIC OF ATLANTIS
RANDY T WARNER, M.D.
690 Dallas Hwy, Suite 201, Villa Rica, GA 30180
Ph: (678) 840-8446 Fax: (678) 840-8482

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 DFT, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose

CONFIDENTIAL

Name: ______________________________ Social Security Number: ______________
Date: ______________________________

Treatment Consent Form

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of The Neuropsychiatric Clinic of Atlantis. This form documents that the client has consented to treatment at The Neuropsychiatric Clinic of Atlantis, including but not limited to psychiatric evaluation and psychotherapy with medication management. This allows the professional staff at The Neuropsychiatric Clinic of Atlantis to provide services to you.

This form provides evidence that no guarantee is made by any professional at The Neuropsychiatric Clinic of Atlantis concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at The Neuropsychiatric Clinic of Atlantis. If you have any questions concerning this or any other matters, it is your responsibility to ask your provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, ____, for ____,
(Print your name) (Print the client's name)

Do hereby voluntarily consent to care and treatment by Dr. Randy Warner,, his assistants and/or designees. I am aware that the practice of medicine, psychiatry, and other therapy by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the treatment process and that I share responsibility for treatment. My responsibilities in treatment include informing the provider of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

____ ____________________
(Sign your name) (Date)

____ ____________________
(Witness) (Date)