Missed & Canceled Appointments

Please arrive on time to your appointments. Failure to do so may result in a canceled appointment with charge. We are only able to see patients at their originally scheduled times.

Foundation Psychiatry, P.C. aims to offer the best care possible to our patients. We ask that you please notify us **at least 24 hours prior** to appointment time for cancellation of appointments. Missed appointments or appointments not canceled **at least 24 hours in advance will be subject to full fee.**

I understand that medications **will only be prescribed at appointments** with the psychiatrist and nurse practitioner. Medication will **not** be refilled outside of session. Call our office in advance to set up a medication management appointment if you feel you will run out before your next scheduled session.

My signature indicates that I understand payment is due at the time of service and that I will pay the full fee for missed appointments or appointments not canceled at least 24 hours prior to appointment time.

___________________________ _________________________ Patient Signature Date

___________________________ __________________________ Printed Patient Name Witness Signature

Failure to comply with therapy, including absence from appointments, may result in cancellation or delay of medication refills

Authorization to Release Health Information

Client Name: ___________________________ Date of Birth: ____________________________

I HEARBY AUTHORIZE **Foundation Psychiatry, P.C.** to release the following medical and clinical information:

- Medical, psychiatric, psychological and therapy evaluations and progress notes - Laboratory Results
- Verbal/Written Communications
- Two Way Conversations
- Treatment Plans
- Exclude the following information: ____ For the

purpose of: __ comprehensive case planning/continuity of care

__ other (specify) _______________________________

with the following:

Name: ____________________________________ Phone/Fax: _________________________

Other: _____________________________________ Phone/Fax: _________________________

Other: _____________________________________ Phone/Fax: _________________________

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. I understand that this authorization to exchange information becomes effective when I sign this release and that I may revoke this authorization at anytime by written notice to Foundation Psychiatry, P.C. However, such a revocation shall not affect any disclosures already made in reliance on your prior authorization. My refusal to sign this form will not affect my ability to receive care at Foundation Psychiatry, P.C. This authorization expires in 12 months and any further disclosure after that time will require signing a new form.

Client Signature: ______________________________ Date:______________________

Signature of Parent/Legal Guardian if applicable:

Signature:____________________________________ Date:_______________________

PATIENT/CLIENT/PARTICIPANT CODE OF CONDUCT

Foundation Psychiatry, P.C. adopts this Code of Conduct in order to define acceptable standards of behavior for patients/clients/participant (referred to as Patient within the remainder of this protocol) and to provide a procedure for action whenever there are grounds to suspect that a patient has engaged in disruptive or unacceptable behavior. All patients, as a condition of their continued treatment by a Foundation Psychiatry, P.C. provider, will abide by Foundation Psychiatry, P.C. rules, regulations, policies, and all other lawful standards.

The code of conduct also applies to chaperones and caregivers who may bring the patient into the office for their appointments.

1. Patient will treat all staff members with respect with words, body language, and gestures. 2. Patient will use office appropriate tone and volume while speaking with staff members 3. Patient will refrain from any form of harassment including violent, verbal, sexual, or physical, to the faculty and patients at Foundation Psychiatry, P.C.
4. Patient understands they will not be seen or treated if under the influence of drugs and/or

alcohol the day of their session.

5. Patient will be considered non-compliant for repeated and/or deliberate violation of Foundation Psychiatry, P.C. rules or policies.

REPORTS OF DISRUPTIVE BEHAVIOR

If any individual working at Foundation Psychiatry, P.C. reasonably believes that a patient is engaging in disruptive behavior or has broken our Code of Conduct protocol, he or she may discuss directly with the client/patient, document the incident, and advise their immediate supervisor as soon as possible.

ACTION

1. Site Manager/Clinic Director will review the information provided.
2. Site Manager/Clinic Director will interview all staff involved, as well as the patient, chaperone, and caregiver.
3. If patient is determined to be in non-compliance with the patient code of conduct, he or she may be discharged or terminated from the practice.

My signature indicates that I understand the Patient/Client/Participant Code of Conduct.

________________________ ______________________________ __________ Patient
Signature Patient Printed Name Date

Controlled Substance (Opioids, Suboxone, Benzodiazepines, Stimulants) Treatment
Patient Policies and Procedures

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I will comply with any treatment regimen prescribed by my psychiatrist, including but not limited to weekly or more frequent individual or group therapy sessions. If I miss a therapy or any similar session and do not immediately reschedule, I will not be prescribed the controlled substance at my next visit with the psychiatrist.

I will not call between appointments, or at night or on the weekends looking for refills. I understand that medications will only be prescribed at appointments with the psychiatrist. If I make more than one contact with the practice (whether by phone, patient portal, email, through someone else, or any other means) in a 24-hour period requesting a medication refill, or if the physician provides a refill outside of session, I will be fined $200, regardless of whether or not the pharmacy fills that medication.

I will use only one pharmacy to get all my medicines.

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will sign a release form to let the doctor speak to all other doctors or providers that I see. I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

I may be subject to random drug screens (e.g. urine, saliva, etc..).

I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped. I will come in for drug testing and counting of my pills within 24 hours of being called.

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

___________________________ ______________________________ _____________ Patient signature Patient name printed Date

EMAIL CONSENT AND GUIDE TO EMAIL USE

As a supplement to your in-office appointments, I am encouraging you to use the electronic medical record patient portal to communicate with my practice. This is preferable to email, as it is more secure. Please choose the patient portal over email. Nevertheless, some patients still prefer to use email due to ease of access. We do not encourage this but if you choose to use email, please read below the policies outlining when and how email should be utilized to best maintain your privacy and to enhance communication. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email will be accessed by Dr. Tumeh or a staff member during the weekdays. You may expect any required response within 1-3 business days.

When may I use email to communicate with Dr. Tumeh or other Foundation Psychiatry staff?

Email may be used to:

- Appointment requests

- Other matters not requiring an immediate response

When should I NOT use email to communicate with Dr. Tumeh or other Foundation Psychiatry staff?

Email should never be used:

- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response

What are the risks of using email?

Risks of communicating via email include but are not limited to:

- Email may be seen by unintended viewers if addressed incorrectly •
Email may be intercepted by hackers and redistributed
- Someone posing as you could access your information.
- Email can be used to spread computer viruses
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters
- Emails are discoverable in litigation and may be used as evidence in court.
- Emails can be circulated and stored by unintended recipients
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment
- There may be an unanticipated time delay between messages being sent and received

What happens to my messages?

- Emails will be printed out and maintained as a permanent part of your medical record
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when the doctor is otherwise legally required to do so.
- Messages may be seen by staff for the purpose of filing or carrying out requests (e.g., appointment scheduling) or when Dr. Tumeh or your other clinicians are away from the office.

What are my obligations?

- I must let Dr. Tumeh/staff know immediately if my email address changes. • If I do not receive a response from Dr. Tumeh/staff in three business days, I will contact him/her by telephone if a response is needed.
- I will use email communication only for the purposes stated above. • I will advise Dr. Tumeh/staff in writing should I decide that I would prefer not to continue communicating via email
- I understand that email may only be used to supplement my appointments with

Dr. Tumeh or other Foundation Psychiatry clinicians and not as a substitute for them.

- To avoid possible confusion, I will not use internet slang or short-hand when communicating via email

What steps has Foundation Psychiatry taken to protect the privacy of my email communications?

Foundation Psychiatry Staff:

- Has installed software for encrypting email messages
- Set up a password protected screen-saver on all computers
- Educated staff on the appropriate use and protection of email
- Do not access patient email from public Wi-Fi hotspots
- Do not allow family members access to personal work computer • Will not transmit highly sensitive information via email
- Will not forward patient email to third-parties without your express consent • Will verify email addresses before sending messages.

What steps can I take to protect my privacy?

- Do not use your work computer to communicate with Dr. Tumeh/staff as your employer has a right to inspect emails sent through the company's system. • Do not use a shared email account to transmit messages.
- Log out of your email account if you will be away from your computer. • Carefully check the address before hitting "send" to ensure that you are sending your message to the intended receiver.
- Avoid writing or reading emails on a mobile device in a public place. • Avoid accessing email on a public Wi-Fi hotspot.
- Make certain that your email is signed with your first and last name and include your telephone number and date of birth to avoid possible mix up with patients with same or similar names.

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself/____________________ (name of patient) and Dr. Tumeh/Foundation Psychiatry staff. I recognize that there are risks to its use, and despite Dr. Tumeh/Foundation Psychiatry's best efforts, he/she cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in the form. I further agree to follow these policies and agree that should I fail to do so, Dr. Tumeh/staff may cease to allow me to use email to communicate with him/her. I also understand that I may withdraw my consent to communicate via email at any time by notifying Dr. Tumeh/staff in writing.

____ Name of

Patient/Guardian Date

____ Signature of Patient/Guardian Email Address

FOUNDATION PSYCHIATRY, PC 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.

HOW WE MAY USE AND DISCLOSE 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. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.
For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Center 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 can 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 Center or the hospital. For example, we may disclose medical information about you to people outside the Center who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.
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 Center and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center 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 Center'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 Center personnel.
POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Center. 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 Center, whether made by Center 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 notice that is 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 include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:
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 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 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 Center. 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 Request Restrictions. You have the 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 for 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 restrictions, you must make your request in writing to the Privacy Officer.
Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Center. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.
Right to Request Confidential Communications. You have the right to request that we communicate with you about 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 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. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Center's

waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact Dr. John Tumeh, Privacy Officer, [404-902-6184], [35 Collier RD NW, Suite 425, Atlanta GA 30309]. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other 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. **I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

____ ______________________________ Patient or Patient's Personal Representative Date

Telemedicine Session

Patient Authorization and Consent Form

Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or other technology to:

- give you advice,
- give you an exam, or
- do a procedure through online communications.

Telemedicine can also be used to:

- get prescription refills,
- book an appointment, or
- let your doctor talk with other providers about your health problem or treatment.

Telemedicine is more than a phone call, an email, a fax, or an online questionnaire. Sometimes you may need to come to a healthcare facility to use their equipment (TV screen, camera, or Internet). A provider may need to use technology tools or medical devices to check on your health remotely. If you agree, part of your health record may be sent to the telemedicine provider before your session.

The team and others involved in your care (e.g., medical home or hospital teams) will make a plan for your care using telemedicine. This will also include a plan in case you have an emergency during the telemedicine session.

Your Telemedicine Session

During your telemedicine session:

- The provider and the staff will introduce themselves.
- When starting a session, you may be asked to confirm the state you are in and the state where you live. •

The provider may talk to you about your health history. Other providers may take part in this discussion. •

A nurse, PA or NP student, or other healthcare staff may be participating in the telemedicine appointment.

- Non-medical staff may be in the room to help with the technology.
- Video and/or photo records may be taken, and audio recordings may be made.

All laws about the privacy of your health information and medical records apply to telemedicine. These laws also apply to the video, photo, and audio files that are made and stored.

Patient Acknowledgment

This form gives you facts about telemedicine sessions. By signing this form, you agree that you have read, understand, and agree with these terms.

I also confirm by my signature below that:

- I have been told the name and credentials of my telemedicine provider,
- I have been able to ask questions about telemedicine sessions,
- All of my questions have been answered,
- I understand no guarantees have been made about success or outcome, and
- I agree to take part in a telemedicine session.

__________________________________ __________________ Signature of Patient,

Parent/Guardian, or Responsible Party Date

____

Patient or Guardian Printed Name