Edward J. Fisher, Jr., M.D., Inc.
1360 Caduceus Way, Building 400, Ste. 102
Watkinsville, GA 30677-7351
706-286-8442 - (fax) 706-310-6907

PATIENT INFORMATION FORM

NAME: _____ Age: _____

DATE OF BIRTH: _____ SSN: _____ Sex: _____

MARITAL STATUS: _____ PRIMARY CARE PHYS: _____

DRIVER'S LICENSE #_____ STATE_____

IF CHILD, GUARDIAN'S NAME: _____

ADDRESS: _____

_____
City State Zip Code

PHONE: _____
Home Phone Cell Phone Other

EMPLOYER: _____ PHONE: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____
Name Relationship to Pt

_____
Address Phone #

Consent to Treatment: **I understand that treatment with Dr. Fisher or one of his associates may involve discussing medical, relationship, psychological and/or emotional issues that at times may be distressing. However, I also understand that this process is intended to help me personally. I further understand that if I have questions, Dr. Fisher or one of his associates will answer them. I understand that I may leave therapy at any time although I have been informed that this is best accomplished in consultation with Dr. Fisher or one of his associates. I have also read the Client Rights and Responsibilities handout.**

SIGNATURE: _____ DATE: _____

PRIMARY INSURANCE INFORMATION

PERSON INSURED: _____ RELATIONSHIP: _____

INSURANCE CO: _____ PHONE #: _____

POLICY #: _____ GROUP: _____

SECONDARY INSURANCE INFORMATION

PERSON INSURED: _____ RELATIONSHIP: _____

INSURANCE CO: _____ PHONE: _____

POLICY #: _____ GROUP #: _____

PERSON RESPONSIBLE FOR PAYMENT, IF OTHER THAN PATIENT:

NAME: _____ Date of Birth _____

RELATIONSHIP: _____

ADDRESS: _____

_____

City State Zip Code

PHONE #: _____

Home Phone Work Phone Cell Phone

SS #: _____ EMPLOYER: _____

DRIVER'S LICENSE #_____ STATE_____

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of medical services rendered by Physician, to the extent permitted by law, I herby (1) irrevocably assign, transfer and set over to Physician (II) all of my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate to other health benefit indemnification agreement, otherwise payable to me for those services rendered by Physician during the pendency of the claim for these services. Such irrevocable assignment and transfer shall be for the recovery on said policy (ies) of insurance, but shall not be constructed to be an obligation of Physician to pursue any such right of recovery. I herby authorize the insurance company (ies) or third party payer (s) providing coverage for services to pay directly to Physician all benefits due for services rendered. I further authorize the release of any medical information necessary to process these claims.

SIGNATURE: _____ **DATE:** _____

I UNDERSTAND THAT AS A COURTESY, INSURANCE CLAIMS, WHEN APPLICABLE, WILL BE FILED FOR ME FOR SERVICES RENDERED. I FURTHER UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF ANY DEDUCTIBLE, CO-PAYMENT, AND/OR OTHER AMOUNTS THAT FOR WHATEVER REASON ARE NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE: _____ **DATE:** _____

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CONSENT FORM FOR RELEASE/SHARE INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SSN: _____

LEGAL GUARDIAN IF PATIENT IS A MINOR: _____

I, _____, give my permission to Edward J. Fisher Jr., MD Inc., it's employees and the person (s) and/or entity (s) and it's employees, listed below to exchange information and/or records regarding the identified patient as stated above. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing a written, signed and dated, request to withdraw the authorization except to the extent that action has already been taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____ _____

Signature of Patient/Guardian Date Signed

Edward J. Fisher, Jr., M.D., Inc.
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1360 Caduceus Way, Building 400, Ste. 102
Watkinsville, Georgia 30677-7351
Phone: 706-286-8442
Fax: 706-310-6907

Name: _____ Date of birth: _____ SSN: _____

Consent to Treatment: I understand that treatment with Edward J. Fisher Jr., MD or one of his associates may involve discussing medical, relationship, psychological and/or emotional issues that at times may be distressing. However, I also understand that this process is intended to help me personally, I further understand that if I have questions, Edward J. Fisher, Jr., M.D. or one of his associates will answer them. I understand that I may leave therapy at any time although I have been informed that this is best accomplished in consultation with the physician or one of his associates. I have also read the Client Rights and Responsibilities handout.

Signature: _____ **Date:** _____

Assignment of Insurance Benefits: In consideration of medical services rendered by Physician, to the extent permitted by law, I hereby (1) irrevocably assign, transfer and set over to Physician (II) all of my rights, title and interest to medical reimbursement, including, but not limited to (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in, accordance with the terms and benefits under any insurance policy, subscription certificate to other health benefit indemnification agreement, otherwise payable to me for those services rendered by Physician during the pendency of the claim for these services. Such irrevocable assignment and transfer shall be for the recovery on said policy (ies) of insurance, but shall not be constructed to be an obligation of Physician to pursue any such right of recovery. I hereby authorize the insurance company (ies) or third party payer'(s) providing coverage for services to pay directly to Physician all benefits due for services rendered. I further authorize the release of any medical information necessary to process these claims.

Signature: _____ **Date:** _____

I UNDERSTAND THAT AS A COURTESY, INSURANCE CLAIMS, WHEN APPLICABLE, WILL BE FILLED FOR ME FOR SERVICES RENDERED. I FURTHER UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF ANY DEDUCTIBLE, CO-PAYMENT, AND/OR OTHER ACCOUNTS THAT FOR WHATEVER ARE NOT PAID BY MY INSURANCE COMPANY.

Signature: _____ **Date:** _____

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CLIENTS RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

Confidentiality is a privilege by law and ethics of the Psychiatry Profession that allows for strictly private discussion of issues that concern you. Any information and/or records about your condition/treatment will not be provided to any other persons or agency without your written permission. Exceptions include:

* Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself and/or others.
*Additionally, Psychiatrists are required by law to report any form of child neglect or abuse, even if only suspected.

Informed Consent refers to your rights to an explanation of your condition and treatment that you can understand. You have a right to participate in the planning of your treatment, refuse treatment, and file complaints/compliments. Treatment often involves addressing concerns that are distressing and you can discontinue at any time, although this is best done in consultation with the Psychiatrist.

Respect and Non-Discrimination are part of your treatment regardless.

Telephone Consultations refer to the occasional need to consult briefly by phone. For the necessary and brief consultations, there is no charge. However, if you wish further assistance, we can either schedule an additional session or we can proceed with our phone session, for which you will be charged the **REGULAR FEE** on a pro-rated basis after the first five minutes. Telephone consultations are not covered by insurance plans.

CLIENT RESPONSIBILITIES

CANCELLATION POLICY requires 24-hour notice for canceling or rescheduling appointments. Missed appointments or late cancellations are subject to the **FULL FEE** since the appointment time was reserved exclusively for you. The office **CANNOT BE HELD RESPONSIBLE FOR APPOINTMENT REMINDERS.** Note that you may leave a message with the answering service after business hours and on weekends by calling 706-475-9704. Continued failure to cancel within 24-hours and/or appointment intervals greater than 12-weeks could result in termination of services. If you fail to cancel 24-hours ahead of time or fail to show for your initial psychiatric evaluation, you will not be offered an appointment for another evaluation unless you pay a fee for your failure. If you are late for a follow-up appointment, we will do our best to work you into the schedule, however we cannot guarantee you will be seen.

Because Dr. Fisher is a medical doctor, there are times when emergencies do arise. This may occasionally result in not being able to see Dr. Fisher at the exact time your

appointment was scheduled. If you are unable to wait, please advise the receptionist so you may reschedule your appointment.

We appreciate the opportunity to serve your behavioral health needs. Please assist us in providing more efficient service to you by contacting your insurance carrier to understand the extent and limitations of your benefits and to obtain required insurance authorization. Failure to obtain proper authorization may unfortunately result in additional charges to you. We also require that when you attend your session you be prepared to provide the co-pay and/or deductible determined by your insurance carrier. It is the patient's responsibility to notify the receptionist of any changes in address, phone numbers, and/or insurance coverage.

DISABILITY FORMS/LETTERS: At some point you may be required by your work or insurance company to have disability forms filled out. Please be advised there is a charge for this service, depending upon the complexity of information required and the length of the forms. Dr. Fisher will determine the cost for filling out such forms after looking over the forms. Payments for these disability forms is due up-front when you bring them to the office. We do not accept forms without pre-payment. Please be sure to sign a **CONSENT FORM** when you drop the forms by the office, which gives Dr. Fisher written permission to release the information to the institution requesting the information.

If you require Dr. Fisher to write a letter for you, please advise the office staff or Dr. Fisher of all pertinent information, which the letter is to contain. There is also a pre-payment for letters written which will be determined by Dr. Fisher. **CONSENT FORMS** also need to be signed for letters written, giving Dr. Fisher permission to release the information to the requesting institution or individual.

Signing this form indicates your acknowledgment that you are responsible **AT THE TIME OF SERVICE** for all charges related to the fee for service not covered by any third party payer, as well as any allowed charges that may remain after third party payments. Signing this form also acknowledges that all treatment interventions are provided with reasonable medical certainty. Treatment planning seeks to achieve an optimal outcome. Undesirable, rarely permanent, side effects can occur in the normal course of treatment and can adversely affect treatment outcome. In addition, an important factor in treatment outcome is full patient cooperation and compliance.

Signature:_____ Date:_____
Witness:_____

EDWARD J. FISHER, JR., M.D., INC.
EDWARD J. FISHER, JR., M.D.
1360 CADUCEUS WAY, BUILDING 400, STE. 102
WATKINSVILLE, GEORGIA 30677-7351
706-286-8442

HIPAA 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.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your doctor may share your health information with a specialist, referring physician or therapist, or hospital staff that will assist in your treatment. Your protected health information may be provided to a physician or therapist to whom you have been referred or who is providing on-call coverage to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided to the staff of Athens Behavioral Medicine, Inc. which manages the billing and records storing in our office. Also, for example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare.

Healthcare Operations: We may use or disclose as-needed, your protected health information in order to support the business activities of your physician's or therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, outside storage of medical records, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sharing Your Health Information: There are situations when we are permitted or required to disclose health information without your authorization. These situations are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as

contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities such as investigations, licensing, audits and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates; for organ and tissue donation; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for worker's compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; and disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

All other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. These requests must be in writing.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Fees may apply.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 706-316-1908. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____
Signature:_____
Date:_____