North Fulton Psychiatric Care, P.C.

1380 Upper Hembree Road Roswell, Georgia 30076
Phone 770-442-1150 Fax 770-772-0416
www.drrickwiner.com

Richard S. Winer, M.D.
Psychiatry
Diplomate, American Board of Psychiatry & Neurology

Today's Date: _____ Referred by: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle or Maiden Name: _____
Date of Birth: _____ Sex: _____ Marital Status: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer's Name: _____ Work Phone: _____
Employers Address: _____
City: _____ State: _____ Zip: _____
Is This Workman's Comp? _____ Yes _____ No Date of Injury: _____
If Yes, Please List: Contact Person at Work: _____ Phone: _____
Attorney: _____ Phone: _____
ALLERGIES: _____
_____

SPOUSE OR PARENT INFORMATION

Last Name: _____ First Name: _____ Middle or Maiden Name: _____
Date of Birth: _____ Sex: ____ Marital Status: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employers Name: _____ Department: _____
Employers Address: _____
City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY

Last Name: _____ First Name: _____ Middle or Maiden Name: _____
Date of Birth: _____ Sex: _____ Marital Status: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employers Name: _____ Department: _____
Employers Address: _____
City: _____ State: _____ Zip: _____

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INSURANCE INFORMATION

Primary – Company Name:_____
Insured's Name: _____ Relationship to Patient:_____
Policy #: _____ Group#:_____
Mailing Address:_____
City: _____State:_____ Zip: _____Phone:_____

Secondary – Company Name:_____
Insured's Name: _____ Relationship to Patient:_____
Policy #: _____ Group#:_____
Mailing Address:_____
City: _____State:_____ Zip: _____Phone:_____

PRIMARY CARE PHYSICIAN

Physician Name:_____
Practice Name:_____
Address:_____
_____
Phone: _____ Fax:_____

THERAPIST

Provider Name:_____ Degree:_____
Practice Name:_____
Address:_____
_____
Phone: _____ Fax:_____

ASSIGNMENT AND RELEASE:

I understand that I am required to pay for sessions with the provider at the time of service and that I hereby authorize North Fulton Psychiatric Care, P.C. to file my claims with the insurance company and that benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services as outlined with my insurance coverage policy. By providing my insurance information to North Fulton Psychiatric Care, P.C., I also authorize the physician to release any information that my insurance company requires to process this claim.

PATIENT SIGNATURE:_____ DATE:_____

GUARDIAN/PARENT SIGNATURE (if minor):_____

TREATMENT CONSENT FORM

CONFIDENTIAL

Name: _____ Social Security Number: _____
Date: _____

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require special consent, and it provides protection for the procedures performed by the professional staff of North Fulton Psychiatric Care, P.C. This form documents that the client has consented to treatment at North Fulton Psychiatric Care, P.C., including but not limited to psychotherapy and counseling. This allows the professional staff at North Fulton Psychiatric Care, P.C. to provide services to you.

This form provides evidence that no guarantee is made by any professional at North Fulton Psychiatric Care, P.C., 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 North Fulton Psychiatric Care, P.C. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, _____, for_____,
(Print you name) *(Print the client's name)*
do hereby voluntarily consent to care and treatment by Richard S. Winer, M.D. his assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work 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 clinician 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)*

North Fulton Psychiatric Care, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, North Fulton Psychiatric Care, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. North Fulton Psychiatric Care, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by a written request to North Fulton Psychiatric Care, P.C. Officer at 1380 Upper Hembree Rd., Roswell, GA 30076.

With my consent North Fulton Psychiatric Care, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my care.

With my consent North Fulton Psychiatric Care, P.C. may mail to my home or other designated locations that assist the practice in carrying out TPO, such as prescriptions, patient statements and any items that assist the practice in carrying out TPO.

I have the right to request that North Fulton Psychiatric Care, P.C. restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to North Fulton Psychiatric Care, P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent North Fulton Psychiatric Care, P.C. may decline to provide treatment.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

(PRINT) Name of Patient or Legal Guardian

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Statement of Members Rights

- ❑ Members have the right to be treated with dignity and respect.
- ❑ Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- ❑ Members have the right to have their treatment and other member information kept private. Only by law, may records be released without member permission.
- ❑ Members have the right to easily access care in a timely fashion.
- ❑ Members have the right to know all about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- ❑ Members have the right to share in developing their plan of care.
- ❑ Members have the right to information in a language they can understand.
- ❑ Members have the right to have a clear explanation of their condition.
- ❑ Members have the right to a clear explanation of their treatment opinions.
- ❑ Members have the right to get information about their insurance's services and role in the treatment process.
- ❑ Members have the right to know the clinical guidelines used in providing and managing their care.
- ❑ Members have the right to information about provider work history and training.
- ❑ Members have the right to provide input on insurance policies and services.
- ❑ Members have a right to know about advocacy and community groups and prevention services.
- ❑ Members have a right to freely file a complaint, grievance or appeal and to learn how to do so.
- ❑ Members have the right to know about laws that relate to their rights and responsibilities.
- ❑ Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Members Responsibilities

- ❑ Members have the responsibility to treat those giving them care with dignity and respect.
- ❑ Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- ❑ Members have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- ❑ Members have the responsibility to follow treatment plans for their care. The plan of care is to be agreed upon by the member and provider.
- ❑ Members have the responsibility to follow their agreed upon medication plan.
- ❑ Members have the responsibility to tell their provider about medication changes, including medications given to them by others.
- ❑ Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- ❑ Members have the responsibility to let their provider know when the treatment plan no longer works for them.
- ❑ Members have the responsibility to let their provider know about problems with paying fees.
- ❑ Members have the responsibility to not take actions that could harm others.
- ❑ Members have the responsibility to report abuse or fraud.
- ❑ Members have the responsibility to openly report concerns about quality of care.

Patient/Guardian:_____Date:_____

NOTICE TO PATIENTS OF DR. RICHARD WINER

Please check in at the front desk upon arrival.

Please make note of your next scheduled appointment. As a courtesy, we will attempt to confirm the day before.

We require 24 hours notice for cancellations to avoid a charge of $50.00.

There will be a $50.00 charge for missed appointments.

Please allow one business day for all prescription requests. No controlled substance prescriptions will be filled during evening, weekends or holidays.

If a prescription is lost, it may be refilled at a lower quantity.

We only file insurance claims when Medicare is the primary coverage otherwise; payment is due at time of service.

There will be a charge of $35.00 for all returned checks.

Your cooperation is appreciated.

Signature:_____ **Date:**_____