Michael S. Conley, M.D., P.C.

315 West Ponce de Leon Avenue, Suite 360, Decatur, Georgia 30030

Phone (404) 681-4100 / Fax (404) 681-2300

michaelconleymd.com

PATIENT INFORMATION

Please print clearly and fill out completely.

PERSONAL AND CONTACT INFORMATION

Last Name: ______________________ **First Name:** ______________________ **MI:** _____

Date of Birth: _____/_____/________ **Social Security Number:** _______/_______/__________

Address: ____

City: ______________________________ **State:** __________ **Zip:** ______________

Phone: ________________________ **Email Address:** ___________________________

Preferred Method of Contact for Appointment Reminders (circle all that apply): Phone Call / Text Message / Email

Emergency Contact Name: ____

Emergency Contact Phone: ______________________ **Relationship to Patient:** ____________

PATEINT DEMOGRAPHICS

Birth Gender: __________ **Gender Identity:** __________________ **Language:** ______________

Marital Status (circle one): Never Married / Married / Divorced / Separated / Widowed / Partnered / Other

Ethnicity (circle one): Decline to Specify / Hispanic or Latino / Not Hispanic or Latino

Race (circle one): Decline to Specify / American Indian or Alaska Native / Asian / Black or African American

Native Hawaiian or Pacific Islander / White or Caucasian / Other: ________________

PHARMACY

Pharmacy Name: ________________________ **Pharmacy Phone:** ________________________

FINANCIALLY RESPONSIBLE PARTY

Please indicate who is responsible for payment, *if* other than yourself

Name: ______________________________________ **Phone:** ______________________

Address: ____

Email Address: ________________________________ **Relationship to Patient:** ____________

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CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of **Michael S. Conley, M.D., P.C.** as they may deem necessary to provide mental health services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from my provider, or until my health care goals are met. If I do not seek treatment for a period of two years, **Michael S. Conley, M.D., P.C.** will consider me self-terminated. The practice reserves the right to terminate treatment for reasons including non-payment of services, missed appointments, misuse of prescriptions or medications and/or inappropriate conduct towards any staff member. This termination may be verbal or in writing. I understand that **Michael S. Conley, M.D., P.C.** does not provide 24-hour, 7-day a week coverage for my medical/psychiatric needs. In case of an urgent or life-threatening situation, I will either call 911 or go to the nearest emergency room.

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Patient, Parent or Legal Guardian Name (PLEASE PRINT)

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Patient, Parent or Legal Guardian Signature **Date**

CANCELLATION AND RESCHEDULE POLICY

Michael S. Conley, M.D., P.C. does not overbook appointments and a specific time slot will be allocated for your appointment. Your clinician and other patients are directly affected if you fail to show up for your scheduled appointment. Every effort is made to see you on time and if you do not come or cancel in a timely manner, your clinician loses that income and cannot effectively fill that appointment time.

- All appointments must be canceled or rescheduled within 24 hours prior to the scheduled appointment time
- Failure to do so will result in a missed appointment charge of $50.00. This fee will be charged regardless of the reason for missing the appointment. This fee is not covered by your insurance company and must be paid before your next office visit.
- Arriving for an appointment without the proper copay will cause a $10 administrative fee to be assessed to cover additional administrative costs
- It is the patient's responsibility to be aware of my appointment date and time. As a courtesy we can provide an appointment card, as well as reminders via phone call, text message and/or email.
- In the event of snow or inclement weather I may cancel an appointment with less than the required notice if the office is called prior to the appointment time.

I acknowledge that I understand and accept consent for treatment and cancellation and reschedule policies of Michael S. Conley, M.D., P.C. By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

____

Patient, Parent or Legal Guardian Signature **Date**

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MEDICATION CONSENT AND REFILL POLICY

Due to the necessity for communication on many levels, refilling medications through pharmacies can be a frustrating experience for both patients and staff. It is of the utmost concern to us that we refill your medications in a timely manner.

It is our policy to give enough medication and refills to treat a patient until their next appointment. It is the patient's responsibility to keep appointments in order to obtain correct dosage of medications. To minimize errors and for your safety, our policy is to not refill medications between scheduled appointments.

We do not, as a rule, prescribe stimulants, benzodiazepines and other controlled medications without evaluating a patient in the office. A police report is required if any medication refills are requested due to loss or theft.

Our clinician(s) may refuse to refill any medication for any reason.

PSYCHOTROPIC MEDICATION POLICY

I hereby consent to receive psychotropic medications as prescribed by my clinician. I have been informed of all the side effects and adverse reactions to the medications. I understand that I may experience withdrawal symptoms if I stop taking prescribed medications abruptly. I understand that, on occasion, some psychotropic medications may be used for psychiatric conditions or symptoms, despite a lack of FDA approval for these uses. I accept this and have had the opportunity to discuss with my clinician my concerns and the possible risks, benefits; precautions and side effects associated with this/these medication(s).

I understand and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my clinician.

If I have further questions or concerns after starting the medication(s), I understand that I should contact the prescribing clinician as soon as possible.

By signing below, I acknowledged that I have read, understood and agreed with both Medication Refill and Psychotropic Medication Policy listed above

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Patient, Parent or Legal Guardian Signature **Date**

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FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to provide quality service while keeping your insurance or other financial arrangements as simple as possible. Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. As medical care providers, our relationship is with you, not your insurance company.

Not all services we provide are covered by your insurance company. Some insurance companies arbitrarily select certain services they will not cover. While filing of the insurance claims is a courtesy we extend to patients, **all charges are your responsibility** from the date the services are rendered.

In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. I accept responsibility for all clinical and administrative services provided by **Michael S. Conley, M.D., P.C.**
2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.
3. I authorize payment to **Michael S. Conley, M.D., P.C.** for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
4. I understand that **Michael S. Conley, M.D., P.C.** will file my claim and attempt to collect payment from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges. It is my responsibility to understand my coverage and benefits, including pre-certifications, referral and authorization requirements. I agree to pay my balance in full if my insurance company fails to pay.
5. I am responsible for updating my personal and insurance information the office with a copy of my current insurance card and driver's license. I am responsible for payment of any medical bills which my insurance company declines due to incorrect or outdated information.
6. Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Failure to pay for your medical bills in a timely manner will result in your termination from the practice.
7. If your plan requires a referral from your primary care physician, you are responsible for verifying that our office has received it. If we do not receive a referral from your primary care physician, we will have to bill you for your visit.
8. We will try to obtain prior authorization for you, but you are responsible for verifying that our office has received it. If your insurance company fails to pay us for our services due to failure to obtain prior authorization, we will bill you directly for the visit.
9. Our office charges $35 for a returned check. If your account has one returned check then you will not be allowed to write checks for future services.
10. We will mail you a monthly statement for outstanding balance. Any balance that is over 90 days past due may be transferred to an outside collections agency for credit reporting and/or may result in your termination as a patient of this practice.
11. Ancillary services performed by any clinician or therapist at **Michael S. Conley, M.D., P.C.** that are provided during non-appointment times will be billed at the provider-specific hourly rate. Typically, these

services are not covered by insurance companies. Examples of such ancillary services include but are not limited to: All patient-related phone calls (including authorized phone consultations with patient or family members, other clinicians, school officials, attorney etc.), crisis counseling, time associated with preparing for non-appointment medication refills, completion of any forms during non-appointment times, etc. Legal and court-related matters are billed at a higher rate and require proof of representation.

12. I allow **Michael S. Conley, M.D., P.C.** to contact any phone numbers or email address that I provide regarding medical and billing issues.

I acknowledge that I understand and accept this financial policy as a patient of Michael S. Conley, M.D., P.C. By signing this form, I acknowledge that I have read, fully understand, and agree to abide by the policies and fees in this agreement.

Patient, Parent or Legal Guardian Name (PLEASE PRINT) ____

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Patient, Parent or Legal Guardian Signature **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.

1. We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at **Michael S. Conley, M.D., P.C.** to provide you with quality care and to comply with certain legal requirements.

2. We may change the terms of our notice at any time. The new notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

3. The following categories describe the ways that **Michael S. Conley, M.D., P.C.** may use and disclose your medical information. Other uses and disclosures of your medical information that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any action we have already taken.
   a. **For your treatment:** Your medical information may be used and disclosed by us for the purpose of providing medical treatment to you for another health care provider providing medical treatment to you.
   b. **To obtain payment for our services:** Your medical information may be used and disclosed by us to obtain payment for your health care bills.
   c. **For our health care operations:** Your medical information may be used and disclosed by us to support our daily operations. These health care operation activities include, but are not limited to, quality assessment activities, employee review activities, training of health care professionals and students, licensing, and conducting or arranging for other business activities.
   d. **For appointment reminders:** We may use or disclose your medical information to contact you to remind you of your appointment, by mail, email, text message or telephone call. Our message will include the name of our practice and/or the name of our physician as well as the date and time for your appointment.
   e. **To our business associates:** We will share your medical information with third party business associates that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information.
   f. **As required by law:** We may use or disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
   g. **As required by the Food and Drug Administration**: We may disclose your medical information to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance, as required.
   h. **To your employer:** We may disclose your medical information concerning a work-related injury or illness to your employer if you are covered under your employer's policy in order to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related injury, in accordance with the law.
   i. **For abuse or neglect:** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your

medical information if we believe that you have been a victim of abuse, neglect, or domestic violence as may be required or permitted by Georgia and/or federal law.

j. **For health oversight:** We may disclose your medical information to a health oversight agency for activities authorized by law.

k. **In legal proceedings:** We may disclose your medical information in the course of any judicial or administrative proceeding, in response to an order of a court of administrative tribunal (to the extent such disclosure is expressly authorized), and in certain cases in response to a subpoena or other lawful request.

l. **For law enforcement:** We may also disclose your medical information, so long as all legal requirements are met, for law enforcement purposes.

m. **Due to criminal activity:** Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use or disclosure in necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

n. **For worker's compensation:** Your medical information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

o. **Regarding facilities:** We may use or disclose medical information if a patient is involuntarily committed to a psychiatric hospital or becomes an inmate of a correctional facility for the purpose of assisting in the patient's medical treatment.

4. Your Rights

You have the right to inspect and copy your medical information. You may inspect and obtain a copy of your medical information that we maintain. The information may contain medical and billing records and any other records that we use for making decisions about you.

However, under federal law, you may not inspect or copy the following records:

Psychotherapy notes; information compiled relating to a civil, criminal or administrative action; and medical information that is subject to law that prohibits access to medical information in certain circumstances.

We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your medical information. This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree with your request. If we agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. Please discuss any restriction you wish to request with your clinician and/or therapist.

5. Complaints

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

I acknowledge that I understand and accept this Notice of Privacy Practices as a patient of Michael S. Conley, M.D., P.C. By signing this form, I acknowledge that I have read, fully understand, and agree to the policies in this agreement.

Patient, Parent or Legal Guardian Name (PLEASE PRINT) ______________________________

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Patient, Parent or Legal Guardian Signature **Date**