Michael S. Conley, M.D., P.C.
315 West Ponce de Leon Avenue, Suite 360
Decatur, GA 30030

Date: _____

OFFICE POLICIES

Thank you for choosing our office for your behavioral health care needs. We look forward to working with you. Please read the following policies and sign acknowledging that you accept the terms. If there is any part that you do not understand or have questions about, please ask for clarification before signing.

INSURANCE: Your insurance policy is a contract between YOU and your insurance company. As a courtesy, we file the insurance claim for you. But please keep in mind that you are responsible for making sure that you are authorized for these visits, and that our office receives payments in a timely manner. Please note you are responsible for notifying us of any changes to your insurance prior to your appointment.

Finally, the co-payment or co-insurance that we collect at your visit is often an estimate. Final co-payment, co-insurance and deductible amounts are determined by your insurance carrier when your claim is processed.

PAYMENT: Payment for services is required at the time of service. This includes co-payments, co-insurance, deductible or past due amounts. We reserve the right to reschedule an appointment due to inability to pay. We accept cash, check, money order, VISA, MASTERCARD, and DISCOVER. There is a $35 charge for returned checks.

APPOINTMENTS: The time of your appointment is reserved for you alone. If you miss an appointment, or cancel less than 24 hours before the scheduled time, we cannot fill that appointment. Therefore, we reserve the right to charge a missed appointment fee of $50, for the doctor's time. 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. Appointment reminders are a courtesy, and are not guaranteed. Please remember, it is YOUR responsibility to keep track of appointment dates and times.

PRIVACY: Privacy is a major priority for our office when dealing with patient's medical information. Therefore, unless we receive written consent from a patient, we will not be in contact with anyone associated with that patient, for any reason.

WAIT TIMES: Dr. Conley does his best to see you in a timely manner. If you are late for your appointment, we reserve the right to consider it a missed appointment and reschedule you for another time. If you come for your scheduled appointment time and find that Dr. Conley is running behind schedule, you may reschedule your appointment without incurring any fees. For the sake of space and privacy, we insist no children, infants, or large groups wait for patients while they receive treatment. Our office can recommend local restaurants and coffee shops where families can enjoy themselves while waiting.

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REFILLS: All medication matters must be handled during scheduled office appointments. It is your responsibility to inform Dr. Conley about what medications you need during your visit. OUR OFFICE WILL NOT CALL IN REFILLS. We make every effort to schedule appointments in a timely manner, to avoid any patient running out of medication before the next visit. Please pay attention to your medications and make sure that appointments are scheduled in the appropriate amount of time so that you don't risk that chance of running out. If you do run out, you will be required to come in to the office for an appointment to obtain a refill. We will make our best effort to work you in.

FORMS AND LETTERS: Thank you for understanding that Dr. Conley's first priority each day is to see the patients in the office. He will complete forms and letters within 10 business days. We charge a fee for all forms and letters, ranging from $25 - $75, depending on the time required for completion. Please note Dr. Conley DOES NOT COMPLETE DISABILITY PAPERWORK. If you are in need of a physician to support a disability claim, please ask us for a referral.

PRIOR AUTHORIZATIONS: Dr. Conley prescribes medications based on your condition and what he believes is your best treatment. Sometimes your insurance company limits your access to medications. These types of restrictions are part of the contract between you and your insurance company. Should your pharmacy advise you that you require a prior authorization for a prescription, please have them fax a request to our office. Once we receive the request, we will begin processing the prior authorization. Please allow 5 business days for this to be completed. Once we have received notification from your pharmacy regarding the outcome, our office will notify you by phone. No charge is required for the initial prior authorization, but if prior authorization is denied you have two options. One choice is that you can ask Dr Conley to prescribe a medication that is approved by your insurance. Your second choice is to pay our office a fee of $35 to handle the appeal process for you denied prior authorization. Please keep in mind that your insurance company is the final decision maker in what they will cover and even after filing for an appeal there is no guarantee of coverage.

TERMINATION OF CARE: Dr. Conley's goal is to provide you medical care until you feel treatment goals have been accomplished, however, you may wish to terminate your care at any time. If you have not been seen for a period of one year, Dr. Conley will consider you self-terminated. Dr. Conley reserves the right to terminate patients for non-payment of services, missed appointments, dishonest use of prescriptions, or for inappropriate behavior or conduct towards staff or himself. This termination may be verbal or in writing.

AFTER HOURS CARE / EMERGENCY ACCESS: For any medical emergency, please call 911 immediately. If you are experiencing a medical crisis and need to go to the emergency room, you can go to the nearest one, or you can go to the Atlanta Medical Center and identify yourself as a patient of Dr. Conley. They will notify him that you are there. Our voice-mail system is available after hours for other concerns. Please allow 2 business days to return calls.

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ACKOWLEDGEMENT OF OFFICE POLICIES

I have read and understand Dr. Conley's policies.

I have read and understand Dr. Conley's privacy practices.

My Signature below authorizes Michael S. Conley, MD to bill my insurance company for charges incurred during the course of my treatment. I further authorize Dr. Conley's office to release any information necessary to process such claims.

Print Name: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____