Neha Khurana, MD Psychiatrist
Georgia Behavioral Health, LLC
GBHPSYCH.COM

4028 Holcomb Bridge Road
Suite 202, Norcross, GA 30092
(678) 861 6463

Welcome to our practice. The following information pertains to our practice policies. We look forward to working with you.

Sessions:

Your initial session is reserved for a thorough review of your history and current symptoms as well as medications. At the end of the session, we will discuss your diagnosis and treatment plan which may include talk therapy, medication management or a combination of both. We will provide you with a list of referrals for talk therapy. This office collaborates with your existing therapist for purposes of coordination of care. We do not provide talk therapy as part of our services. You may not be prescribed medications after your initial session if the provider does not deem them necessary. At the end of your first session, you may be referred out if our provider assesses that you will benefit from a higher or different level of care. This may include referral to Partial Hospital or Intensive Outpatient Programs or referral to a Community Service Board.

Follow up appointments may be scheduled from 1 week to 4 months after your initial appointment based on the provider's recommendation. The frequency of follow up appointments may vary depending on response to medications, severity of illness and side effects. Medication management appointments are 15-30 minutes in length depending on the type of medication and ongoing issues that are being addressed. Please note that our office does not offer same day or crisis appointments.

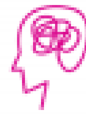
All paperwork is filled out in session with the patient and guardian present and at the discretion of our providers. This includes any school forms, FMLA, disability applications or any other form of documentation required for work/ school/ legal purposes. A $50 fee applies to each application being filled out. Our office does not fill out disability paperwork unless you have been an established patient with at least three visits with our provider.

Cancellations and No-Shows:

Your appointment time is reserved for you. Therefore, if you are not able to keep your appointment time, please call as soon as possible to cancel or reschedule your appointment. If you do not provide at least 24 hours' notice of your cancelled appointment or if you fail to show for your appointment, you will be charged a no-show fee of $50.

Contacting Us:

We will answer calls during business hours Monday-Friday. We will return phone calls within 24 hours with the exception of weekends and holidays. If you are experiencing an emergency and cannot wait to reach me, you should call 911 or go to the nearest emergency room. As soon as you are able to do so, please contact me to inform me of the situation. You can also reach the Georgia Crisis and Access Line at www.gcal.com. Please do not send us text messages or emails regarding your medications. Medication changes are best addressed in session with our providers.



Financial Policy

We will bill your insurance company, but you will be asked to pay your co-pay or applicable balance in case you have not met your deductible. Payment will be required prior to the start of the session.

I understand that it is my financial responsibility for services provided until insurance deductible is met and any co-pay thereafter or if my insurance becomes inactive, but I continue to seek services from GBH, LLC.

Full payment is due at the time service is rendered. I acknowledge responsibility for all fees incurred including those for documentation, no shows, late cancellations, prescription refills. All balances 30 days past due will be deemed delinquent. Delinquent accounts must be paid in full before any future services will be provided. We reserve the right to send delinquent accounts to collections if needed.

For minor children of divorced parents - Payment is expected from the parent(s) bringing the child for treatment irrespective of the divorce decree. We will release pertinent medical records only to the custodial parent. Parent who has signed financial responsibility paperwork will be held accountable for delinquent account.

I have read and understand the above policies.

Patient's Name Date

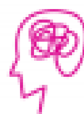
Responsible Party's Name (if patient, indicate "self") Date

Responsible Party's Signature Date

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential,and under ordinary circumstances this privilege can be waived only by the patient. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1)the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/ or has made specific threats to harm an identifiable third person,(3)actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you first.

I have read and understand the above policies.

Patient's Signature Date



POINTS TO REMEMBER

1. Notify me if there are any significant changes in your psychiatric or medical condition, or if an outside provider changes your medication regimen.

2. Notify me if you suspect or know that you are pregnant or plan to become pregnant in the near future. Pregnancy will affect treatment recommendations.

3. If you feel you are at risk of hurting yourself or others, notify me immediately. If you feel you are an imminent risk and need immediate attention, call 911 or go to your nearest emergency room.

4. I welcome emails for non-urgent, administrative communication. Please note that the confidentiality of your email cannot be guaranteed. To discuss medical concerns, please call us at 678-861-6463 or email us at georgiabehavioralhealth@gmail.com to schedule an appointment.

5. If your medication makes you drowsy or slow your reaction time, please refrain from driving, and notify me. Also, notify me if your medication causes you other significant side effects. It is advised to not drink alcohol while taking psychiatric medications.

6. If you want to increase, decrease, or discontinue your medication regimen, please call us first. Medication management is a collaborative process. Changes without consultation from the provider could jeopardize your health and well-being and may interfere with our ability to work together and constitute as grounds for dismissal from our practice.

7. If you are seeking treatment with a service/therapy/emotional support animal, our practice does NOT provide these services and are NOT trained in these areas to prescribe to our patients. Also, we do not write any letters or documentaions for your animals, so please refer to professionals that are trained in these areas to receive your documentation.

8. Please remember to schedule your follow up appointment at the end of your session. Any medication refills called outside of your routinely scheduled appointment generate a $25 fee and are at the discretion of your provider. Controlled substances may not be called in without an appointment. Our office checks the Ga PDMP prior to prescribing controlled substances to stay compliant with Georgia law.

9. Following are grounds to terminate patients from our practice -

a. 3 or more missed appointments in a 12-month period
b. 3 or more cancellations with less than 24 hours' notice in a 12-month period
c. Abuse of prescribed medications
d. Positive urine drug screen for patients on controlled substances
e. Rude, aggressive, inappropriate, or hostile behavior towards staff, providers, or other patients.

I have read and understand the preceding Points to Remember.

Patient's Signature | Date

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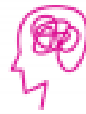

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NEW PATIENT INFORMATION SHEET

Name ____ Age ________ DOB____________________

Address ____

City ________________________ State _________ Zip Code ________________

May we send mail to this address? **Y or N**

Phone ______________________________ May we leave a message? **Y or N**

Email____

Employer ________________________________ Occupation __________________________________

Marital Status **(Circle one):** single married domestic partnership separated divorced widowed

Emergency Contact ________________________________ Relationship _____________________

Emergency Contact Phone ____

Referred by ____

May we reach out to your referring provider to provide a brief synopsis of your visit today? **Y or N**

Please briefly describe the problem or situation that has prompted you to call and seek treatment.

____

____

What are your goals for treatment?

____

____

Have you received psychiatric care in the past for this problem or for any other problems? Please provide names of prior providers including therapists and psychiatrists.

____

____

Have you ever been hospitalized for psychiatric reasons? If so, please provide details of the hospitalization.

____

____

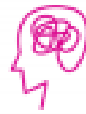
Pharmacy Information

Please make sure to provide all the pertinent information listed or this may delay the sending of your prescriptions.

Name______________________________________ Phone____________________________________

Address____

City________________________________ State__________ Zip Code_____________________________



Medical History

Date of most recent physical exam: ____________________

Medical Conditions:

____

____

Allergies:

____

Any family history of psychiatric conditions?

____

____

Name of primary care physician: ____

Address:

____________________________________ City ____________________ State ____________ Zip ________

Phone: ____________________________________

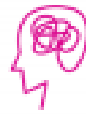
For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?

Y or N

If Yes, I,_____________________________,give permission to Dr. Neha Khurana to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

____

Patient's Signature Date



Current Medications -List any medications you are currently taking including herbs/supplements

Medication Name	Dosage	Why Taking	Response

Past Medications -List all psychiatric or neurological medications taken in the past

Medication Name	Dosage	Why Taken	Why Stopped

Substance Use History-Please specify amount and frequency

Alcohol Past___ Current___ ______________________________

Tobacco Past___ Current___ ______________________________

Marijuana Past___ Current___ ______________________________

Cocaine Past___ Current___ ______________________________

Opiate Past___ Current___ ______________________________

Benzodiazepines Past___ Current___ ______________________________

Stimulants Past___ Current___ ______________________________

Ecstasy Past___ Current___ ______________________________

Other Past___ Current___ ______________________________

Have you ever been in substance abuse treatment or rehab in the past? Please describe.

____

_

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_

Please note any other information about yourself that you think might be helpful in understanding you.

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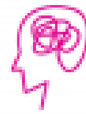

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CONSENT FOR RELEASE OF INFORMATION

Please complete for any providers that you would like me to collaborate with including therapists, primary care physicians and other specialists

Patient Name____ Date of Birth _____________

I, ______________________________________, hereby authorize Dr. Neha Khurana to release information from my medical records as described below to

Name: ____

Address: ____

____

Phone Number:__________________________________ Fax:____________________________________

Email: ____

The request and authorization apply only to the following information:

___MedicalHistory/PhysicalExam
___Discharge Summary
___Psychiatric Reports/Tests
___Psychiatric Evaluations
___TreatmentRecommendations
___LaboratoryReports
___Summary of Hospitalizations
___Psychological Reports
___Medications
___Course of Treatment
___Consultations
___Progress Notes
___Teachers' Reports
___Social History
___Developmental Hx
Other____________________

The purpose of the release of information is: ___Coordination of Care ___Continuation of Care

The release will expire in 12 months unless specified by you. I understand that I can cancel this authorization at any time, except for action that has already been taken.

____
Signature of Patient (12 years and older) Date

____
Signature of Guardian Date

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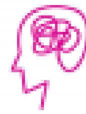

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Credit Card Authorization Form

24 Hour Cancellation Policy- If Dr. Khurana does not receive notice outside of 24 hours prior to the cancellation of your scheduled appointment you will be charged $50 for a no-show appointment. Signing this agreement authorizes our office to charge the card listed below for missed appointments.

Please complete the information below:

I________________________authorize **Georgia Behavioral Health** to charge my credit card (full name) indicated below for payment of Psychiatric services for the following individual(s):

Print Full Name: ____

Credit card will be charged after each appointment for services rendered. Authorization can be cancelled at any time with written consent.

BillingAddress__________________________________ Phone #___________________________

City,State,Zip_________________________________ Email_____________________________

SIGNATURE___________________________________ DATE______________________________

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Account Type: Visa MasterCard Amex Discover

Cardholder Name____

Account Number____

Expiration Date______________

CVV(3digit number on back ofVisa/MC, 4 digits on front ofAMEX)______________