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.

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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.

Parent/Guardian's Signature Date

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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.

Parent/Guardian's Signature Date

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CONSENT FOR EVALUATION AND TREATMENT

I am legal guardian of _____ and with full legal authority to consent to treatment.
(**child's name)**

I hereby consent to psychiatric evaluation and treatment of him/her by Neha Khurana, MD.

Parents, Informed Consent & Divorce: If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that you may be in violation of a court order if you fail to inform the other parent of your child receiving psychiatric services. Also note to provide consent for treatment of your child you must either have sole legal custody OR have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. By signing below you are stating that you have the legal right to consent for this child. In the case of separation or divorce, any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to attention that are irrelevant to the child's welfare may be kept in confidence.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

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Medication and Prescription Policy

If Dr. Khurana is prescribing medications to you/ or your child as part of your treatment, regular follow up visits with her are required to closely monitor for efficacy, safety and potential side effects. Medication management requires working together to ensure the best response to medications. This includes maintaining scheduled follow up appointments.

- You will be prescribed enough medication to last until your next follow-up appointment. **Prescriptions will not be called in for patients that cancel/ or miss regularly scheduled medication follow-up appointments.**

- If you have to reschedule an appointment, please ensure that you schedule another appointment before you run out of medication. Our office will do our best to reschedule you, but keep in mind it may take several days to weeks to find an appointment that will be conducive to your schedule. **It is your responsibility to make sure you do not run out of medicine.**

- Controlled Substances - Recognize that stimulant medications and Benzodiazepines are considered controlled substances and cannot be called in to or faxed to pharmacies. If you lose a prescription or your medication, it is at Dr. Khurana's discretion to issue a replacement. All controlled substances will have to go through the Georgia PRMP in accordance with the guidelines.

Dr. Khurana is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the medication policies, understand, and agree with them.

Patient's Signature: _____

Guardian if Minor: _____

Date: _____

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NEW PATIENT INFORMATION SHEET

Date:_____ Referred By: _____

Name of Child: _____
What name would your child like to be addressed by?
_____
What is the name on your insurance card?
_____
Age:_____

Date of Birth: _____

Male/Female/Other:_____ What are their pronouns? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mother's Name: _____ Father's Name: _____

Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____
Home Phone: _____ Home Phone: _____
Email: _____ Email: _____
Occupation: _____ Occupation: _____
Education: _____ Education: _____

If address is different from above, please list below:

Address: _____ Address: _____
City: _____ City: _____
State: _____ Zip Code: _____ State: _____ Zip Code: _____

Child's Legal Guardian (s): _____

Primary Residence of Child: ___Both Parents _____Mother ____Father _____
___ Other (specify): _____

Relationship Status of Parents: _____Never Married. _____Separated _____Widowed
_____Married/Partnership _____Divorced

Please note any custodial or legal arrangements pertinent to the child's medical care:

_____

_____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____
Phone: _____ Work: _____ Home: _____
Address: _____ City: _____
State: _____ Zip Code: _____

Primary Care Physician:

Name of Pediatrician: _____
Address: _____ City: _____ State: ____ Zip Code:_____

For purposes of continuity of care, may we contact your psychiatrist and/or therapist 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.

_____
Parent/ Guardian's Signature Date

Pharmacy Information (If medications are prescribed):

Pharmacy Name_____

Phone_____

Address_____

City_____ State_____ Zip Code_____

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School Information:

Name of School (indicate if homeschooled)_____Grade: _____

Address: _____ City: _____State: ____ Zip: _____

Please identify members of the child's household:

Name	Age	Relationship	Living In the Home (Yes/No)	Occupation

Please describe your reason(s) for seeking treatment at this time (include when the problem started):

_____

_____

_____

How does your child's current problem impact family relationships or family functioning?

_____

_____

_____

Describe how your child gets along with other children? Has your child's current problem affected peer relationships?

_____

_____

Describe your child's experience and function in school? Are there any problems?

What are your goals for your child's treatment?

What are your child's strengths and/or unique qualities?

What are your child's interests and hobbies?

Psychiatric History:

Has your child received other outpatient psychiatric care in the past? Please provide name of prior providers including psychiatrists and therapists.

Has your child ever been hospitalized for psychiatric reasons? If so, please provide dates and name of hospitals.

Is there any family psychiatric history eg. bipolar disorder, anxiety, depression, schizophrenia, substance abuse, learning disorders, ADHD, autism? Please provide condition and which family relative.

_____

_____

Is your child currently seeing a psychiatrist and/or therapist? ____ Yes _____ No

Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____
Phone: _____

For purposes of continuity of care, may we contact your psychiatrist and/or therapist 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.

_____
Parent/ Guardian's Signature Date

Developmental History:

How much did your child weight at birth? _____lbs

Were there any developmental delays including speech/walking/gross or fine motor skills? Describe.

_____

_____

_____

Any complications during pregnancy or delivery? If so, please describe

_____

_____

_____

Medical History:

List any significant medical problems such as seizures, head injuries, accidents, hospitalizations:

_____

_____

_____

Any history of chest pain, palpitations, murmurs, fainting, or post exercise symptoms? Please describe:

_____

_____

_____

Allergies: _____

_____

Any family history of medical problems (include seizures, heart disease, diabetes, cancer, liver disease, stroke, Parkinson's)? If your child is adopted, please answer based on biological history if known

_____

_____

_____

Any family history of early heart disease (before age 30)?

Please note any other information that you think might be helpful for me to better understand your child and family:

Current Medications -List any medications your child is 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

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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	___LaboratoryReports	___Consultations
___Discharge Summary	___Summary of Hospitalizations	___Progress Notes
___Psychiatric Reports/Tests	___Psychological Reports	___Teachers' Reports
___Psychiatric Evaluations	___Medications	___Social History
___TreatmentRecommendations	___Course of Treatment	___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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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)_____