ROSWELL PSYCHIATRY

Michael J Rosen, M.D.

Jessica Mathisen, M.ED, LPC

11755 Pointe Place, A-1
Roswell, GA 30076
&

1012 Coggins Place
Marietta, GA 30060

WELCOME PACKET

Welcome to our practice and THANK YOU for entrusting us with your care.

Our patients are very meaningful to us and we take our responsibility to you very seriously. In order for our practice to work smoothly and efficiently for all, we have implemented the policies described on the following pages.

Please do not hesitate to ask us any questions you may have.

We look forward to a productive relationship with you!

OFFICE PROCEDURES/POLICIES

This is an agreement between Michael Rosen, M.D., and
the Patient/Legal Guardian/Guarantor.

In this agreement, the words "you", "your", and "yours" always refer to the Patient/Legal Guardian/Guarantor. The words "we", "us", and "our" always refer to Michael Rosen, M.D. and his associates.

APPOINTMENTS:

Initial appointments are considered a consultation visit, and we will determine if our services will be appropriate to meet your needs. If for any reason we determine that we will not be appropriate for your care, referral sources will be provided to you.

Office visits are scheduled for specific dates and times, and every effort is made to see you on time. We do not double-book our schedule. To help us keep on schedule, it is important for you to arrive at least 10 minutes before your scheduled appointment.

Follow-up appointments can be made three different ways:

1) In out office at the time of your previous appointment.
2) By telephone call to our office at (404) 450-0338, Mon-Fri (8am-8pm).
3) Through the online Patient Fusion Portal.

CANCELLATIONS: If you cannot keep your appointment, you must give a minimum 48-hours notice of cancellation to avoid a charge for your scheduled appointment time. Cancellations can be made either by telephone call to our office at (404) 450-0338 Mon-Fri (8am-8pm) or online through the Patient Fusion Portal. On the Portal, you can either cancel directly on the scheduler or you can send a message to our office requesting the cancellation.

Please Note: In keeping with the 48 hour advance cancellation policy:
a) Cancellations for a Monday appointment must be made no later than the previous Thursday at the same time of your appointment.
b) Cancellations for a Tuesday appointment must be made no later than the previous Friday at the same time of your appointment.

Failure to provide the above notice will result in a missed appointment charge as follows:

a) \$375.00 for initial appointment with psychiatrist (MD)
b) \$200.00 for initial appointment with master level therapist
c) \$135.00 for follow-up visit with psychiatrist (MD) and master level therapist

As we have reserved this scheduled time for you, these charges are your responsibility. You will be charged to the credit card we have on file for you and you hereby agree to pay these charges.

If you are more than (15) fifteen minutes late for your appointment, you will be charged as above per the "failure to provide notice of cancellation" schedule above.

If you are ill or have another emergency, please notify the office as soon as possible by phone at (404) 450-0338, Mon-Fri (8am-8pm).

As a courtesy, we have implemented an email reminder system for your appointments. Please note, if you have indicated that you would like to receive appointment reminders by email, these reminders are only a courtesy and it is your responsibility to remember your appointment time. The missed appointment charge will not be waived if you do not receive a reminder.

INSURANCE AND APPOINTMENT FEES:

As physicians and therapists, our relationship is with you, not your insurance company. As a courtesy to you, we will send our bill to your insurance company if you are covered under an insurer with whom we participate. <u>All charges are your responsibility from the time services are rendered.</u>

It is <u>YOUR</u> responsibility to contact your insurance company and ensure that we participate in your plan. It is also <u>YOUR</u> responsibility to understand your coverage and benefits, including deductible amounts, pre-certifications, referral, and authorization requirements. We are not responsible for knowing the requirements of your specific plan. We will try to assist you to ensure that all plan requirements are met, but you are ultimately responsible to ensure coverage. Please be aware that some, and perhaps all, of the services you receive may not be covered by your insurance company. <u>You are financially responsible for any services provided by our office whether or not those services are covered by your insurance plan.</u> Please also note that that certain insurances will not cover services for two providers at one location on the same day (i.e. a patient may not be allowed to see both their therapist and psychiatrist on the same day).

You are responsible to notify us of any insurance changes before your next appointment.

INSURANCE "RESPONSIBILITY": Any insurance claim that has not been covered/paid (denied for any reason) by your insurance plan becomes YOUR responsibility to pay 90 days after our proper initial filing of the claim. We will promptly re-file the claim should there be any errors on our part noted as cause of denial. Any payment due must be made before your next appointment. Additionally, you must pay any claim that is denied due to your insurance being inactive at the time of services, or due to failure on the part of the patient or responsible party to obtain prior authorization or referral and/or complete the forms required by the insurance company to process the claim, before your next appointment. All delinquent balances must be paid in full before any further services will be provided.

PATIENT RESPONSIBILITY: The unpaid patient responsibility balance is due no later than 60 days after the date of service. Patient responsibility includes, but is not limited to, co-pays, deductibles, co-insurance and fee for service. As a courtesy, statements are automatically sent to those with an unpaid patient responsibility balance on a monthly basis. Any balance that is past this date is deemed delinquent, and you agree that we may charge the credit card on file with us for this balance. All delinquent balances must be paid in full before any further services will be provided. Failure to pay a balance will result

in collection actions and you may be discharged from the practice. If a patient's balance is turned over to a collections agency, an additional 25% of the balance will be added to the account. Patients/Guardians/Responsible Parties are responsible for notifying our office of any changes to address or other contact information.

If we are not a participating provider with your health insurance, we do NOT send bills for out-of-network benefits to other insurers. We will gladly furnish a statement for you to provide to your insurance company to obtain reimbursement. It is your responsibility to file with your insurance company. *We will require payment before the time services are* rendered, and reimbursement will be provided to you directly from your insurance company.

If we are not a participating provider on your insurance plan, the cash payment fees for our services are as follows:

a) $375.00 for initial appointment with psychiatrist (MD)
b) $200.00 for initial appointment with master level therapist
c) $135.00 for follow-up visit with psychiatrist (MD) and master level therapist

PAYMENTS: Payments can be made by personal check, certified check, credit or debit card. For the safety of our staff, we do not accept cash.

Please be advised that each bounced check occurrence will incur a $50 fee.

MEDICATIONS:

It is our policy to give a <u>maximum</u> of 90 days of medication at the time of your appointment (including refills). In many cases, a much shorter period of time is appropriate and necessary. It is your responsibility to remain current with needed appointments so that there is no lapse in medication. You must be seen in the office a minimum of once every 120 days. If you fail to meet this requirement, you will be considered "inactive" and discharged from the practice with no further medication prescribed. Readmission to the practice will require a new "initial" appointment.

REFILLS: Medication refills between appointments are at our discretion. For your health/safety and the highest care possible, please note that these "inter-appointment" refills are a rare exception. If refills are needed between appointments, we require 72 hours advance notice. At our discretion, we will provide up to one month's supply of medication. We expect you to be seen in the office before using up the "inter-appointment" refill.

There is a $15.00 fee for providing refills outside of appointments. You are required to remain compliant with our appointment requirements to ensure no lapse in medication. We reserve the right to refuse refilling any medication if we believe it is clinically necessary to evaluate you before prescribing medication.

Please note, we do not respond to pharmacy requests for refills as they are frequently inaccurate and often automated.

PRIOR AUTHORIZATION: Should you find that your insurance requires prior authorization for a prescribed medication, please note that this process may take up to 7 business days. Prior authorizations require a significant investment of our time, and therefore there is a $25 fee for completion. Prior authorizations are typically required on an annual basis by your insurance company. Please check with your insurance company or pharmacy for the results of prior authorizations. Often, your pharmacy will be notified of the result and communicate that to you.

HOW TO CONTACT US

EMERGENCIES AND URGENT MATTERS:

In the event of an emergency (immediate attention is required for oneself or another due to a life threatening situation or a potential threat to safety), call 911 or go to the nearest hospital emergency room.

If you have an urgent matter and need to contact us, you may call the office directly at (404) 450-0338 (Mon-Fri 8am-8pm). We will promptly return a phone call for any urgent matter (such as a significant side effect of medication). If an urgent matter arises after those hours, you may contact us through the Patient Fusion Portal or via the OhMD app (see below).

PHONE CALLS:

Any non-urgent matters, such as the routine need for medication changes in dose or formulation, therapeutic issues, or any other non-urgent concern should be addressed during appointment times or using the OhMD app or through the Patient Fusion Portal (see below). In the rare event that a non-urgent matters requires a phone call to our office, please call (404) 450-0338 (Mon-Thurs 9am-5pm) our front office staff will return your call as soon as possible.

OhMD:

For your convenience, you can use the "OhMD" app (available on iphone and android) as an optional means of communication with us. This app is HIIPA compliant.

PATIENT FUSION:

For your convenience, you can enroll in the online portal "Patient Fusion" as an optional means of communication with us. This Portal is HIIPA compliant.

FORMS/LETTERS/RECORD REQUESTS:

Any additional forms, letters, or records that a patient requests will require a signed *Release of Information form. This form may be printed off of our website and must be* submitted to your Provider prior to the form being completed. These requests require at least (5) five business days for completion and it is your responsibility to provide sufficient advanced notice.

There is a $25 fee for a clinician to complete any brief letter/form. Any forms/letters that require extended time, such as legal forms, disability forms, intensive school/camp forms, will be billed on a pro-rated basis commensurate with the above listed cash rates.

In addition, should you need a copy of your medical records to be sent to another physician, therapist, or any other provider, this may take up to 10 business days to complete. The fee to compile and send these records are as follows: $25 administrative fee plus $.50 per page.

TERMINATION OF SERVICES:

Any patient who has not been seen by us nor contacted our office regarding an upcoming appointment for more than 120 days will be considered no longer under our care and will be discharged from the practice. These patients may call us again at any time to schedule a new intake appointment. Additionally, there are other possible reasons for permanent termination of services including but not limited to: non-payment of fees, three or more missed appointments, abusive behavior toward staff, abuse/misuse of prescribed medication. If termination becomes necessary, you will be provided referrals for alternate care. Emergency care will be provided for you for 30 days.

MICHAEL ROSEN, M.D.

11755 Pointe Place, A-1
Roswell, GA 30076
&
1120 Coggins Place
Marietta, GA 30060

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.

Your medical records are confidential and protected by state and federal laws including the federal Health Insurance Portability and Accountability Act (HIPAA). Protected health information is information about your health record that may identify you.

Uses and Disclosures of Protected Health Information:

Treatment: We may use or disclose your health information to provide, coordinate and or manage your health care services and treatment. We may disclose your health information to other healthcare professionals, such as therapists, doctors and/or nurses who also provide services to you to ensure proper coordination of care. All employees of Michael Rosen, M.D., are required to sign a workplace confidentiality agreement, and agree to access only the minimally necessary healthcare information in carrying out their primary job function.

Payment: We may use or disclose your health information to bill and collect payment for the services that we provide to you. This may involve office staff, health insurance organizations, or other businesses that may become involved in helping to collect unpaid balances.

Health Care Operations: We may use and disclose information about you for health care operations. These operations include, but are not limited to, quality assessment, cost management, employee review, and business planning activities. We may use or disclose medical information about you to remind you of an upcoming appointment, to check on you after you have received treatment, to obtain prior authorization for a treatment, etc. We may disclose your information to contractors (business associates) who provide

certain services to us. Privacy and confidentiality is very important during the treatment of children and adolescents. Many parents/caretakers want to know what transpired in psychotherapy sessions with children/ adolescents. However, some degree of confidentiality is essential in order to develop a therapeutic alliance (particularly with adolescents). This alliance subsequently improves the quality of their psychiatric care. Therefore, our providers will use their clinical judgment in deciding whether and when to relay information to parents that has been revealed to clinicians by patients. In most cases, if it is felt that information needs to be communicated to parents, patients will be encouraged to communicate this information themselves. In clinically urgent or emergent situations, we will likely relay the information to parents directly.

1) Serious threat to health or safety- If we determine that you present a serious danger or threat to yourself or another, we may disclose information to provide protection for you or the intended victim.

2) Abuse/ Neglect- We will report to the appropriate authorities any circumstances of child abuse or neglect, elder abuse or neglect, or abuse or neglect directed towards a disabled person.

3) Legal proceedings- We may disclose protected health information if required to do so by law i.e. court order, subpoena, etc. Our providers also reserve the right to use and disclose information about you if doing so is necessary to defend our providers from any legal action brought against our providers in relation to your care.

4) Public Health Responsibilities/ Communicable diseases/ Matters of National Security

5) Worker's Compensation- We may disclose protected health information if necessary in compliance with laws relating to worker's compensation or other similar programs.

6) Health Oversight Activities- We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure, etc.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your medical records. You must complete a written request and submit it to our privacy officer. There may be a fee for providing copies of medical records—please enquire about these fees to front office staff. We may restrict your right to protected health information/psychotherapy notes in certain circumstances as allowed by law.

Restrictions: You have the right to request a restriction of your protected health information. This means you may ask us not to disclose your information for the purposes of treatment, payment, or healthcare operations. Please contact our privacy officer if you want to request any restrictions. We do not have to agree to the restrictions that you request.

Amendment: You have the right to request an amendment to your healthcare information if you feel it is incomplete or inaccurate. You must submit your request in writing to our privacy officer, and include an explanation of why the information should be amended. Your request may be denied in certain circumstances.

Right to an Accounting of Disclosures: You have a right to receive a paper copy of this Notice, which you may request at any time. We reserve the right to change the terms of this notice, and will post any changes in our front office and on the practice website.

Questions and Complaints: You have a right to file a complaint with us if you feel we have not complied with our privacy policies. You may request a complaint form from the privacy officer and submit your complaint in writing. You may also complain to the Dept. of Health and Human Services. We will not retaliate against you if you file a complaint.

How to contact us:

11755 Pointe Place, A-1
Roswell, GA 30076
404-450-0338

INFORMATION FORM

PATIENT

Name: ______________________________

Date of Birth: ______________________________

SSN: ______________________________

Email: ______________________________

Street: ______________________________

City: ______________________________

State: ____________ Zip: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

EMERGENCY CONTACT

Name: ______________________________

Relationship: ______________________________

Street: ______________________________

City: ______________________________

State: ____________ Zip: ______________________________

Cell Phone: ______________________________

PRIMARY CARE PHYSICIAN

Name: ______________________________

Phone: ________________ FAX: ________________

Street: ______________________________

City: ______________________________

State: ____________ Zip: ______________________________

PHARMACY

Name: ______________________________

Phone: ______________ FAX: ______________

Street: ______________________________

City: ______________________________

State: ______________ Zip: ______________

PARENT/LEGAL GUARDIAN

(Please fill out if Patient is under 18 years old)

Name: ______________________________

Relationship: ______________________________

Street: ______________________________

City: ______________________________

State: ______________ Zip: ______________

Email: ______________________________

Cell Phone: ______________________________

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT

(Please fill out if other than Patient)

Name: ______________________________

Relationship: ______________________________

Street: ______________________________

City: ______________________________

State: ______________ Zip: ______________

Email: ______________________________

Cell Phone: ______________________________

Date of Birth: ______________________________

HEALTH INSURANCE

We are currently contracted with Aetna, Blue Cross and Blue Shield, United Healthcare and Medicare.

Is the Patient covered by ANY of the above health insurance plans?
Yes ☐ No ☐

If Yes, please fill out below:

Insurance Company Name: ______________________________

Provider Services Phone #: ______________________________

Group Name/Number: ______________________________

Primary Policy Holder (this is the individual named on the policy):

____

Primary Policy Holder Date of Birth:

____

Primary Policy ID Number: ______________________________

Effective Date: ______________________________

Please provide your ID card so that we can make a copy of it

COMMUNICATION/CONTACT

Timely and clear communication is key to a successful working relationship. We have arranged three different ways that we can communicate with you/your legal guardian. Please fill out information below ONLY for ways that you agree to be contacted. We will ONLY contact the person listed below. Please indicate your order of communication preference below by numbering {1, 2, 3}.

Contact Name: ______________________________

Relationship: ______________________________

Phone/Voice: { } ______________________________
I consent for staff to leave a voicemail (check one): Yes ☐ No ☐

Email: { } ______________________________
By furnishing my email above, I consent to contact through the "Practice Fusion" software (HIIPA compliant)

Text: { } ______________________________
By furnishing my text # above, I consent to contact through the "OhMD" app. (HIIPA compliant)

Appt. Reminder Email: ______________________________
As a courtesy to you, we have implemented an electronic appointment reminder system. By furnishing your on the line email above, you request/consent to use of this email address above for appointment reminders.

IMPORTANT POINTS TO REMEMBER

1. If you/your child are an imminent threat to self or others, call 911 or go to your nearest emergency room.
2. Notify your provider if there are any significant changes to your/your child's psychiatric or medical health
3. Do not email the practice with any urgent clinical matters. Patients should discuss any clinical concerns directly with their provider. Emails may be sent for administrative purposes after providing advanced verbal notice to our front staff.
4. Please discuss with your provider before increasing, decreasing, or discontinuing any psychiatric medication. Medication changes without consultation can be dangerous
5. It is your responsibility to notify your provider if you are pregnant or plan to become pregnant.
6. Refrain from driving if your medication makes you feel drowsy or otherwise impaired and notify your provider.
7. It is advised not to drink alcohol or use illegal substances while taking psychiatric medication.

I have read, understand, and agree to the above important points to remember.

____ _______________

Signature of Patient or Legal Guardian (if patient under 18 years old) Date

FOR PARENTS/LEGAL GUARDIANS:

To provide consent for psychiatric treatment for a minor, you must have either sole custody or shared legal custody of the child. If you share legal custody, and your legal arrangement requires that you notify the other parent of health appointments, it is your responsibility to do so. Please note that any clinical matter discussed during an appointment with one parent present may be discussed with the other parent as well.

By signing below, you are certifying that you are the Parent/Legal Guardian of

______________________________ (minor's name) and that you have legal authority to consent to treatment for your child. You also agree to notify us if your custody arrangement changes.

___________________________________ _______________

Signature Legal Guardian (if patient under 18 years old) Date

CREDIT CARD POLICY AND CONSENT

I, the undersigned, authorize Michael Rosen, M.D. to charge my credit card for the following services or conditions:

- Missed appointments or cancellations not meeting the cancellation requirements herein:

i. $375.00 for initial appointment with psychiatrist (MD)
ii. $200.00 for initial appointment with master level therapist
iii. $135.00 for follow-up visit with psychiatrist (MD) and master level therapist

- Co-Payments (unless paid by check or credit/debit card at the time of the appointment)
- Any claim that is denied secondary to insurance being inactive at the time of service, or due to failure on the part of the patient or responsible party to obtain prior authorization or referral and/or complete forms required by the insurance company to process the claim (unless otherwise discussed and agreed by us).
- Any insurance claim that has not been covered (denied for any reason) by your insurance plan becomes YOUR responsibility 90 days after our proper initial filing of the claim.
- The unpaid patient responsibility balance is due no later than 60 days after the date of service.
- Any bounced check amount plus a $50 bounced check fee.
- $50 for providing each "inter-appointment" prescription.
- $25 fee for completing any brief letter/form.
- $25 administrative fee plus $.50 per page for a copy of your medical records to be sent to another physician, therapist, or any other provider.
- $25 fee for completing each "Prior Authorization" form.

Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

Credit Card #: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name on Card: ______________________________

Exp Date: ____________________ CVC: __________

Signature: ______________________________

Billing Address: ______________________________

Billing City, State, Zip: ______________________________

Patient Name: ______________________________

HEALTH INFORMATION RELEASE/REQUEST FORM

Consent & Authorization to Release/ Request Medical and Mental Health Information.

I, (first name, last name) ____

Date Of Birth: ______________________________

hereby authorize Michael Rosen, M.D. to release/request (circle one or both) the following information and records obtained in the course of my diagnosis and treatment. I understand that these records may contain confidential information about psychiatric treatment, substance abuse or dependency, sexuality, and communicable diseases such as HIV/AIDS.

(Please check all that apply)

- ☐ **Medical Records**
- ☐ **Lab Results**
- ☐ **Psychiatric Assessment and Diagnosis**
- ☐ **Medication Management Information**
- ☐ **Other (please specify) ____**

Name of individual/organization	Address	Phone number/Fax
______________________	____________________	(___)______________
______________________	____________________	(___)______________
______________________	____________________	(___)______________
______________________	____________________	(___)______________
______________________	____________________	(___)______________

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by us to be effective. I understand that any use or disclosure/request made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and that my treatment or the treatment of those under my guardianship shall not be affected. I understand that I am voluntarily signing this form to release/request my health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.

Signature: ______________________________
(Patient, Parent or Legal Guardian)

Date: ______________________________

If Parent or Legal Guardian:

Name: ______________________________

Relationship to Patient: ______________________

ACKNOWLEDGEMENT

I have received and read the Michael Rosen, M.D. "Welcome Packet" (including our Office Procedures/Policies, Notice of Privacy Policies and Notice of my Rights with Respect to Health Information). I understand and agree to all the policies. I understand that I am responsible for all charges incurred for the above services, including those not paid by my insurance company. I understand the policies regarding missed appointment fees. I understand that these policies are subject to change, and these changes will be posted in the front office as well as on our website. I understand it is my responsibility to keep abreast of all policy changes. I consent to treatment including psychotherapy and/or medication management. Any questions I have asked have been answered to my satisfaction. My signature serves as acknowledgement and agreement to the above.

____

Print Name of Patient or Legal Guardian

____ ________________

Signature of Patient or Legal Guardian **Date**

I have been provided with a copy of the Michael Rosen, M.D. Privacy Practices and HIPAA Notice regarding the use and disclosure of PHI (Protected Health Information) for treatment, payment, and healthcare operations. I understand these policies.

____

Print Name of Patient

Patient Date of Birth: __________________________

____

Print Name of Parent/Legal Guardian (If Patient is under 18)

____ ________________

Signature of Patient or Legal Guardian (If Patient is under 18) **Date**