Angel Luis Perez MD, LLC
5887 Glenridge Drive,
Suite 230 Sandy Springs, GA 30328
Phone (770) 255-4655 FAX (770) 255-4672
www.drangelluisperez.com

BUSINESS POLICY ~ CONSENT for TREATMENT ~ PATIENT INFORMATION

If you are contacting us for a NEW PATIENT, please call the office before filling out this form. Thank-you

Please read this information carefully and discuss any questions you may have with your doctor. This form MUST be completed and delivered to your provider prior to the date of your first appointment. E-sign it online in your portal or email it to: Office@drangelluisperez.com.

PORTAL: Our practice management software, Simple Practice, will ask you to set up an online portal for your connection with your provider. Please be on the lookout for an email invitation to set up your portal and enter the required information.

CREDIT CARDS ON FILE: We require that a valid credit card be placed on file prior to any services. HSA cards require a backup credit card. You will be able to enter or update your credit card information in your portal. You may also call your provider to provide your credit card information. (770) 255-4655. All appointments are charged to your credit card at the time of service. Any exception must be approved by your provider.

NO SURPRISES ACT Federal regulation form: Our fees are listed below in compliance with Federal legislation. Psychiatric Physician New Patient 60 min $440, New Patient 90 min $540, follow up 55 to 65 min (scheduled as 60 min) $395, follow up 38-52 min appointment (scheduled as 45 min) $325, follow up 16-37 min appointment (scheduled as 25 min) $230.
For more information on the "No Surprises Act": https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.
Extended sessions: are billed at a somewhat higher rate. Prescriptions filled outside of an appointment are $25 so notify your provider of your refill needs in your appointment. Expedited prescriptions are $45.

APPOINTMENT REMINDERS: Simple practice has an appointment reminder system to text or email you or both, 48 hours in advance of your appointment and at the time the appointment is created. Please look for these reminders.

TELEMEDICINE: Dr. Perez provide appointments that are conducted by Telemedicine Synchronous video or in some instances telephone. Dr. Perez use embedded video in Simple

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Practice, which are HIPPA compliant and confidential telemedicine platforms. No sessions are recorded.

TELEPHONE CALLS: To communicate with Dr. Perez, please leave a voice message through my voice-mail system, (770) 255-4655 or a write a message in the Simple Practice portal (prefer option by Dr. Perez). Dr. Perez checks his mailbox regularly and will make every effort to return your call as soon as possible. There is no charge for brief phone calls. Therapeutic phone calls, calls longer than fifteen minutes, medication discussion/changes by phone or phone calls to 3rd parties (other providers, hospital, emergency department, attorneys etc. will be charged according to the time and level of service involved.

EMERGENCIES: If you have an EMERGENCY, please call 911 or go to your nearest emergency care facility. My voicemail box is not appropriate for emergencies calls.

EMAIL: For security and privacy/confidentiality reasons, Dr. Perez do not use email for therapeutic communications SO, please **DO NOT** email medication questions, change requests, side effect symptom/issue discussions, or appointment changes/cancellations. All these matters should be handled by leaving a voice mail or your portal (prefer method by Dr. Perez). You may send third party documents or test reports to office@drangelluisperez.com or upload them on your portal (prefer method by Dr. Perez). Please notify Dr. Perez prior to sending any documents. Dr. Perez will assume that you wish him to review documents submitted. Any time spent reviewing documents sent will be charged at his standard rates according to time spent.

Rx REFILLS, Rx PRIOR AUTHORIZATION: To request a prescription refill, send a message through Simple Practice portal. Please make sure to write the name, dose and instructions of the medication as well as the address of the pharmacy to which it will be send. Allow THREE full business days for your provider to complete. Dr. Perez use e-Prescribe. Dr. Perez will make every effort to accommodate urgent (within 24 hours) Rx refill requests ($45/per day regardless of number of Rx's) if the request is received by noon of that day, please make sure that you start your message at the portal with “Expedite prescription”. Prescriptions filled outside of an appointment are $25. Prior authorizations with your insurance company are often required for you to have your Rx paid by insurance, they are time consuming and are billed at $35 each, regardless of approval. Dr. Perez do not respond to direct pharmacy refill requests as they are often inaccurate or out of date.

CANCELLATIONS: If you must cancel an appointment, as a courtesy to Dr. Perez, please do SO well in advance through Dr. Perez’s voice mailbox (770) 255-4655 or your portal (prefer method by Dr. Perez). Any appointment that is cancelled less than TWO BUSINESS DAYS in advance will be charged for the time reserved for you as your provider would be unable to assign the time to someone else. If you have questions regarding this policy, discuss it with Dr. Perez. Simple Practice will in most cases send an email or text reminder 48 hours in advance of your appointment. Dr. Perez does not call you to remind you of your appointment. If you are not able to cancel in time, you may switch to a Tele Health or phone appointment. Please call Dr. Perez and notify him of your need to switch.

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INSURANCE: Dr. Perez do not file insurance claims, nor do our providers participate in any insurance plans, however, many services we provide are covered by insurance as "out of network benefits." Some insurance companies fraudulently list us as in-network providers, but we have never signed with any companies. Since coverage varies widely from policy to policy, we cannot guarantee that these services will be reimbursed by your insurance carrier. You may file for reimbursement directly with your insurance carrier. At the time of your appointment, your physician or therapist will give or mail you a super-bill. Attach it to the "physician's section" of your insurance claim form and file it directly with your insurance company to obtain any reimbursement.

MEDICARE, TRI-CARE and MEDICAID OPT OUT: Our providers have "opted out" of these governmental plans therefore you agree that if you have coverage under any of these plans, you will not file for reimbursement with them as this is in conflict with governmental regulations for "opted-out" providers.

BILLING/OUTSTANDING BALANCES: All fees are payable in advance on the date of service. If you should have an outstanding balance at the end of the month, you will receive a monthly statement of your account, which is payable on receipt. Balances over 30 days due are deemed delinquent, the total amount due will accumulate with interest added at the rate of 1.5% per month until it is paid in full. Should your account have to be collected through an attorney or our collection agency, you will also be responsible for all reasonable attorneys' fees and all costs of collections. If your account is placed with a collection agency, a collection fee in the amount of 7% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will also be responsible for all costs of collection including attorney fees and court costs. You agree, that if we should need to collect any amounts you may owe, we and/or our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or our collection agencies may also contact you by sending text messages or email messages, using any email address or telephone number you have provided to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MINOR PATIENTS TURNING to ADULT AGE: As guarantor of payment for a minor patient, you accept responsibility for all charges incurred providing care to this patient regardless of patient reaching age of majority unless you rescinded guarantor status in writing to Dr. Angel Luis Perez MD, LLC. The Adult patient will then need to fill out and sign a consent for treatment once they reach the age of 18 years.

OTHER IMPORTANT FACTORS IN TREATMENT: The success, length and outcome of treatment is affected by many things including the severity of the problem, the match between the therapist and patient, the motivation of the patient, among other factors. Please

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discuss with Dr. Perez your expectations and feelings about treatment. The best outcome is achieved through collaboration between the patient and provider.

CONSENT FOR TREATMENT/CONFIDENTIALITY: Communication between a patient and a physician will be held in confidence and will not be released without your written consent unless specifically required by law (for example: suspected child abuse, imminent threat of danger to yourself or others, or court order.) Group therapy, marital therapy and work with adolescents may involve different legal issues around confidentiality. Please ask if you have concerns about these issues. Information released to insurance companies for reimbursement for services is released only on authorization from you. However, if you waive confidentiality for your insurance company, they may request that your record for treatment be released.

DISCONTINUATION OF TREATMENT: Typically, the decision to terminate therapy is made as a mutual thoughtful decision involving the physician and patient. A provider may also decide to discontinue care for noncompliance of a treatment plan or repeated failing to make appointments. If you discontinue treatment without notifying your provider, we will deem that your therapeutic relationship with us terminated 30 days after your last visit beyond which we carry no further responsibility for your care, unless you have an appointment scheduled for a future date. If you have been prescribed any medications, we urge you to not modify your medication program without contacting your psychiatrist first. Abrupt termination of many medications prescribed may have serious adverse effects on your health. Please discuss any medication changes with your physician including medications or over the counter substances added or changed by you or other medical providers outside Dr. Perez. If you have not been seen in over one year and then decide to return to care, you will be considered a NEW PATIENT.

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Patient Name: F: __________________ L: _____________________________ DOB: __/___/____ Age: ___

GENDER: M_ F_ Other ____, Occupation/School Grade: ____

Parent/Guardian if not patient: ________________________________ Relationship: _________________

Please describe reasons for seeking care: ____

____

____

____

Patient's Medical/ Surgical/ History: ____

____

Medications/dose/how taken: ____

____

Please list all other immediate family members below:
Name: F:___________________ L:_________________________ Relationship to Patient: ________________

DOB: ___/____/____ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _______________

Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____________________________________

____

Name: F:___________________ L:_________________________ Relationship to Patient: ________________

DOB: ___/____/____ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _______________

Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____________________________________

____

Name: F:___________________ L:_________________________ Relationship to Patient: ________________

DOB: ___/____/____ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _______________

Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____________________________________

____

Name: F:___________________ L:_________________________ Relationship to Patient: ________________

DOB: ___/____/____ Age: _____ GENDER: M_ F_ Other ____, Occupation/School-grade: _______________

Lives at home? Yes / No; Medical/Surgical/Emotional Problems: _____________________________________

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COMMUNICATION WITH OTHER PROFESSIONALS:
May your therapist discuss your care with your referring professional? Yes ___ No ___

Referring Professional: ____________________________________ Telephone (_____) ______-_________

Address: _____________________________________ City: _____________ State: ____ Zip: ___________

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TELEMEDICINE SERVICES ADDENDUM

Patient Information and Informed Consent for Telepsychiatry Service

Telepsychiatry is the delivery of psychiatric or psychotherapeutic services using synchronous interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

• A computer and a webcam with microphone to video conference using Zoom, Doxy, Face Time or Skype software readily available to all computer users.

Potential benefits

• Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry.
These risks include, but may not be limited to:
• Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
• The provider may not be able to provide medical treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure.
• Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
• Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
• A lack of access to all the information that might be available in a face-to-face visit but not in a telepsychiatry session may result in errors in medical judgment.

Telemedicine: My Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
• I understand that the technology used by the provider is encrypted and is HIPPA compliant to prevent the unauthorized access to my private medical information.
• I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

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• I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during the course of my care at any time.
• I understand that all rules and regulations which apply to the practice of medicine in the state of Georgia also apply to telepsychiatry.
• I understand that the provider will not record any of our telepsychiatry sessions without my written consent.
• I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

Telemedicine: My Responsibilities
• I will not record any telepsychiatry sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
• I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and agree to revert to a telephone voice session utilizing the indicated backup telephone number provided below should a video connection not function properly.
• I have read and understand that all clinic policies of the Angel Luis Perez MD, LLC apply to all telemedicine as well as all in-person visits
• I understand that **I agree to be seen in person at least once a year** to maintain therapeutic services and a provider/patient relationship.
• I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in the office **in person prior to commencing telepsychiatry treatment.**
• I consent to paying fees that are that same as an in-office visits for the type and length of service provided as described in the "New Patient Policy."
• **I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be and should I not be available for the appointment or cancel it less than two full business days in advance, it will be charged as a missed appointment for the time my practitioner has reserved for a scheduled appointment.**

SIGNATURE PAGE
I hereby give my informed consent for my or my child's care and authorize my provider to use of telemedicine in the course of my diagnosis and treatment.

Please sign acknowledging that you consent to all the above policies and have kept a copy for your records. If you have any questions or issues to resolve about any business matters, please discuss them with your provider.

Responsible Party Signature/Information: I acknowledge that I have read and accept this policy and consent for treatment of myself or my minor child listed herein and accept responsibility for all fees

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incurred. I have also had on opportunity to review and have been offered a copy of the "HIPAA NOTICE OF PRIVACY PRACTICES" policy. If the patient is a minor child, I acknowledge that I have the legal authority to consent for treatment of this child.

Unless you indicate otherwise, you acknowledge that we may contact you at any of the numbers you have provided. If you do not wish to be contacted, please indicate here ( ). If you do not allow contact, you may not receive important clinically relevant communications from us.

Responsible Party Printed Name if different from patient:

First: _____ MI: _____ Last: _____

SSN: __ __ __ -__ __-__ __ __ __ DOB: ____/_____/_____ Relationship to patient: _____

Patient's name: F: _____ L: _____ DOB __/__/____

Street: _____; Apt: _____

City: _____; State: _____; Zip; _____

Home: (____) _____-_____; Work: (_____) _____-_____; Cell: (_____) _____-_____

Email: _____@_____._____

Responsible Party Signature: _____ Date: ____/_____/_____

Relationship to patient: _____

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