TRIAD PSYCH, P.C.
20 Years Strong · TriadPsych.org

707 Whitlock Ave SW #G6 Marietta, GA 30064
2487 Cedarcrest Rd #724 Acworth, GA 30101
199 Armour Dr NE #E Atlanta, GA 30324
200 Glen Eagles Court #14B Carrollton, GA 30117

New Patient Information Form

Patient Name:_____ Patient DOB:_____

Responsible Party:_____ Relationship:_____ DOB:_____

Responsible Party SS#: - -

This field is REQUIRED in the event you or your child's financial obligation is not met by our financial agreement. Triad will make all reasonable efforts to bill your assigned insurance carrier. But if contracted payment cannot be recovered from your insurance carrier, as a last resort we will initiate collections activity only after exhausting all other means including requesting payment from the responsible party. Please Initial: _____

CONSENT TO TREATMENT

I consent to have Triad Psych, PC perform evaluation, assessment, psychotherapy or related services as deemed appropriate. I understand that I may be offered a referral for other mental health services as needed. I understand this statement please initial. _____

If services are for a minor, do you have medical decision-making authority? Y N
please initial here_____

If "NO" to the above statement, who has medical decision-making authority? _____

CONFIDENTIALITY

Information regarding your treatment will not be released unless there is written consent OR an indication that clear and immediate danger to self or others exists OR you disclose sexual or physical abuse or neglect of a child, disabled or elderly person. please initial. _____

Consent for Use & Disclosure of Protected Health Information (PHI): I hereby give my consent for Triad Psych to use and disclose Protected Health Information (PHI) about me or my child to perform treatment, payment and healthcare operations (TPO). I have the right to review with my clinician Triad's privacy practices and modify them in agreement with Triad management. With this consent, Triad Psych may call

my home, cell phone or other alternative location and leave a message with a person or voice mail in reference to any items that assist the practice in administering TPO such as appointment reminders, insurance items and any calls pertaining to me or my child's clinical care including test results, etc. With this consent, Triad Psych may use un-encrypted e-mail to my home or other alternative location any items which assist the practice of in administering TPO, such as appointment reminders and statements. I have the right to request that Triad Psych restrict how it uses or discloses my PHI to administer TPO. However, the clinic is not required to agree to my requested restrictions, but if it does it is bound by this agreement. With my signature I am consenting for Triad Psych to use and disclose my PHI to administer TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Triad Psych may decline to provide treatment to me or my child. _____ please initial

FINANCIAL POLICY

Payment is expected at the time of service, unless there is a previous agreement for payment. PLEASE NOTE: It is the responsibility of the patient/responsible party to see your insurance guidelines for PRECERTIFICATION are followed. All insurance co-payments are to be collected at time of service, unless other arrangements have been made. As a courtesy, our software vendor, Therapy Appointment will send you both a text and email reminder 24 and 48 hours before an appointment, failing to respond to said reminder does not constitute a notification of cancelation. A full charge of $100.00 for appointments will be made to the patient and or responsible party if the office is not notified 24 hours in advance regarding cancellation. Dissatisfaction with services does not excuse the obligation to pay for services. All court/forensic work will be paid for in advance by the party initiating the service. Patient/responsible party will be responsible for all legal and collection fees on balances including clinician lost time, collection agency fees and magistrate court charges if it is handled through those means. I have read and understand this statement. please initial____

NO SURPRISES ACT/GOOD FAITH ESTIMATE

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. Most of the services at Triad Psych are billed to insurance companies. Yet there are certain services provided which are not covered by insurance or are only partially covered by insurance. This includes but is not limited to testing, report writing, filling out of forms, etc... In these instances, patients are entitled to a written Good Faith Estimate (GFE) from their clinician. Make sure your therapist gives you a Good Faith Estimate in writing at least one business day before your first appointment. You can also ask your therapist, and any other provider you choose for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. Triad will also save a copy of your GFE to our software system for reference. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call your chosen therapist.

TERMINATION/FINISHING WELL

How we finish is just as important as how we begin. We'll begin to discuss termination when your goals move towards completion. If you start to think about wrapping up therapy prior to this, bring it up to discuss in session. We ask that you give a minimum 2 session notice which allows one session for us to explore you or your child's termination readiness and a final session to process the journey, progress and identify specific "take-aways" from the work you've accomplished._ _ _ _ _ please initial

GUARANTEE OF PAYMENT

I give my personal guarantee of payment for all charges herein incurred. I attest that all of the above statements are true. I authorize the release of information to my insurance company.

Signature Patient/Responsible Party:_____ Date: _____