David Lipsig, M.D., LLC
3715 Northside Parkway
Building 100, Suite 500
Atlanta, GA 30327
404-738-8800

PATIENT INFORMATION:

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____Zip: _____

Home Phone: _____ Alternate Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: MALE / FEMALE

Who referred you to this practice? _____

Is it okay to leave a message for you from us (circle one)? YES / NO

If so, what telephone number do you prefer us to use? (_____) _____ - _____

PERSONAL INFORMATION:

Patient's Employer: _____ Phone: _____

EMERGENCY CONTACT: _____ PHONE: _____

Person responsible for charges incurred: _____

Relationship to Patient: _____ Phone: _____

If the person responsible for the bill is other than the patient, please complete Guarantor Form.

If Patient is a Minor or Student Dependent:

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

INSURANCE INFORMATION (Complete only if you have Medicare or Medicaid):

Dr. Lipsig has opted out of Medicare. You will be responsible for fees incurred. If you have Medicare and want to be treated by Dr. Lipsig, it is required that you and Dr. Lipsig enter into a separate contract (see our website or contact the office for the contract). It is also required that you agree to not submit claims into Medicare for treatment with Dr. Lipsig.

Do you have Medicare (circle one)? YES / NO

Do you have Medicaid (circle one)? YES / NO

Dr. Lipsig is not a Medicaid provider and cannot treat Medicaid patients. Please inform our office prior to treatment if you have Medicaid. We can try to provide you with a name of a Medicaid provider.

MEDICAL INFORMATION:

Allergies (Circle one)? YES NO List all: _____

Medications taking at present: _____

Primary Physician: _____ Phone: _____

Have you recently had any thoughts of hurting yourself and/or anyone else? YES / NO

RECORD RELEASE AUTHORIZATION:

I hereby authorize David Lipsig, M.D., LLC to furnish information to insurance carriers concerning this treatment.

Patient's signature: _____ Date: _____

CONSENT FOR TREATMENT:

I hereby agree to be treated by David Lipsig, M.D. I agree that I am personally responsible for ensuring that all charges for services rendered are paid.

Patient's signature (Parent or Guardian, if minor): _____

Date: _____

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

____ VISA ____ MasterCard _____ American Express _____ Discover

_____ _____ _____
Name as it appears on card Sec. Code Billing Zip Code

_____ - _____ - _____ - _____ _____/_____
Credit / Debit Card Number Exp. Date

I/we authorize David Lipsig, M.D., LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I understand the charge on the billing statement will be recorded as "LipsigLLC." I will notify David Lipsig, M.D., LLC, in writing if I no longer want my credit / debit card billed.

_____ _____
Signature of cardholder Date

CREDIT CARD PAYMENT for LATE CANCELLATION OR NO-SHOW

I authorize David Lipsig, M.D., LLC to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

_____ _____
Signature of cardholder Date

GUARANTOR INFORMATION (complete only if the patient is NOT paying for the bill):

Name of party responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Date of Birth: _____/ _____ / _____ SS#: _____

Guarantor-Financial Responsibility Agreement

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

Signature: _____ Date: _____/_____/_____

DAVID LIPSIG, M.D., LLC POLICIES

OFFICE HOURS:

Office hours are Monday through Friday by appointment only. All first appointments are considered a consultation only. Dr. Lipsig will let you know if he is in the position to offer treatment services beyond the first appointment.

PAYMENT/INSURANCE INFORMATION:

Fees are due at the time services are rendered. Our office does not contract with any insurance companies. However, if your insurance company provides out-of-network benefits, you may file your own claims for reimbursement. These claims should be paid directly to you. At the end of each appointment, if requested, you will receive a statement that contains the necessary documentation to file with your insurance company. Please let our office know if you would like to receive this statement. We recommend that you contact your insurance company for specific information about your out-of-network coverage for mental health services.

In addition, Dr. Lipsig has opted out of Medicare. If you have Medicare, you can be seen on a Private Contract basis, in which no Medicare claims are made. Please click here to download the contract. We do not accept Medicaid.

We accept credit and debit cards as a convenience.

For current fee schedules, please call our office.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients will be charged the full session rate when cancellations occur unless notice is given at least one business day in advance. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.

ELECTRONIC MAIL (EMAIL) POLICY

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature. Additionally, the doctor will save your email correspondence and these communications should be considered part of your medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature. The doctor will make an effort to check email regularly; however, call our office if you have not received a reply within 72 hours.

TELEPHONE POLICY:

Routine brief phone calls made between the hours of 9 a.m. and 4:30 p.m. on weekdays will be returned as quickly as possible; calls will typically be returned the same day. Routine calls received after 4:30 p.m. or on weekends will be returned the following business day.

For more extensive phone calls, please schedule a phone appointment with the doctor. There will be a routine charge for these phone calls based on the time spent per call. Please note that most insurance companies will not reimburse for phone consultation fees.

MEDICATION REFILL POLICY:

Medication refills will generally be called in to the pharmacy within one business day after the request is made. When requesting a refill, please provide:

- Your date of birth
- Name of medication requested
- Medication dosage
- Pharmacy telephone number and address

Prescriptions may only be called in for current patients who maintain their regularly scheduled appointments. Medication refills will not be called in over the weekend except in emergencies.

TERMINATION POLICY:

It is the position of this office that the patient and doctor should mutually agree when it is time to terminate the therapeutic alliance. Ideally this time comes when the patient's treatment goals have been achieved and there is a reasonable expectation that the gains will be maintained. There are, however, circumstances in which there is not mutual agreement, and it is these situations that are addressed below.

Patient Initiated Terminations

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly. At the patient's request, the doctor shall furnish three referral sources for individuals or agencies that could continue the patient's treatment.

Doctor Initiated Terminations

Although rare, there are times that the doctor would terminate treatment without the patient's consent. Potential reasons where this might occur including the following: the patient refuses to cooperate with treatment; conflict of interest; the patient fails to pay the agreed upon fees or the doctor determines that he is no longer the best psychiatrist to provide treatment.

If the doctor judges that there are reasons to justify termination of treatment (and the patient does not agree), the doctor shall make an effort to discuss the issues with the patient and give the reasons for termination when appropriate. In addition, the doctor will mail the patient a letter

explaining the termination of treatment, providing names of at least three psychiatrists and providing availability for emergency care for 30 days from the date of the letter.

Please note that it is Dr. Lipsig's view that successful treatment requires that both the doctor and the patient agree to the treatment plan. An essential part of a successful treatment involves consistency with the agreed upon frequency of the treatment appointments. Dr. Lipsig will discuss the recommended frequency of appointments throughout treatment and, typically, at the end of each appointment. However, if the patient does not follow-up as recommended or decides to not follow up with treatment at all, we ask that the patient inform the office. However, if the patient does not contact the office to let us know the intentions, it can become unclear if the patient has any plans to continue treatment.

If the patient does not follow up with the recommended frequency of treatment appointments, the patient's status will be changed from "active" to "closed/inactive." Please note that the closed/inactive status signifies that Dr. Lipsig and the patient have ended their doctor-patient relationship. Therefore, Dr. Lipsig has no clinical responsibility at this point.

Either of the following situations will result in a change to "closed/inactive" status:

1) Patient does contact the office or follow-up with Dr. Lipsig within 30 days of the recommended time frame that he told the patient at the end of the appointment, and which is documented in the chart.
2) Patient does not contact the office or follow-up with Dr. Lipsig within 4 months from their previous appointment unless a separate written agreement has been made with Dr. Lipsig.

If this should occur, the former patient may request to be "re-established" as an active patient and return to treatment if approved by Dr. Lipsig.

ACCEPTANCE OF POLICIES:

David Lipsig, M.D., LLC is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly, we require that agreements be made regarding the policies stated above. Patients are encouraged to ask questions before signing.

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

Patient's signature: _____

Guardian if a Minor: _____

Date: _____

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the treatment. In that way the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy your health record, amend your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For additional information about our health information practices or to report a problem, you may contact Dr. Lipsig at 404-738-8800. A full copy of this notice is available from Dr. Lipsig. If you believe your privacy rights have been violated, you can file a complaint with Dr. Lipsig or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

My signature below indicates that I have read the notice of privacy practices.

Signature: _____ Date: _____

David Lipsig, M.D., LLC

3715 Northside Parkway
Building 100, Suite 500
Atlanta, Georgia 30327
404-738-8800

Patient Information and Informed Consent for Telepsychiatry Service

Telepsychiatry is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and 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 or phone with a webcam with microphone for video conference.
- An internet connection with adequate connectivity and speeds.

Potential Benefits

- Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals with limitations that interfere with travel to our office (examples include busy work and/or home schedules, a desire to avoid traffic, being away from home at college, work related trips or vacation, etc.).

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:

- Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the doctor and the doctor makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the doctor will call the patient back by the phone number provided.
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by the doctor.
- The doctor may not be able to provide 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.

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 doctor is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry at any time during the course of my care.
- I understand that all the 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 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 or verbal permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I am solely responsible for maintaining the strict confidentiality of the provided Zoom link/ Meeting ID # and I will not allow another person to use this link to access this service. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.
- I understand that the company (Zoom) that the doctor has chosen to conduct the telehealth appointment is an independent company the provides the online platform to peform these appointments in a secure manner. My doctor has no responsibility for that company's operations or the security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the doctor is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.
- I will not record any telepsychiatry sessions without written consent from the doctor. I will inform the doctor if any other person can hear or see any part of our session before the session begins.
- I understand that I, not the doctor, am responsible for providing and configuring any electronic equipment used on my computer or phone 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 I agree to revert to a telephone voice session utilizing a backup telephone number should a video connection not function properly. If I am experiencing any technical difficulties, the officc encourages me to call/contact the company chosen for online appointments for technical support.
- I have read and understand that all of the clinic policies of David Lipsig, M.D., LLC apply to all telemedicine as well as all in-person visits.
- I understand that I agree to be seen face-to-face if this is a requirement or if the doctor recommends it.
- I consent to paying fees that are the same as an in-office visit for the type and length of service provided, by using a credit card number provided to David Lipsig, M.D., LLC or by a check mailed to the office at the time of service.
- I understand that a telepsychiatry scheduled appointment has the same late cancel/no show policy as an in-office appointment. Therefore, should I not be available for the appointment or cancel it less than one full business day in advance, there will be a charge for a missed appointment for the time my doctor has reserved for the scheduled appointment.

I have read the above Informed Consent for Telepsychiatry Services, understand, and agree with them.

Signature: _____ Date: _____