David S. Deuser, M.D. & Associates

Patient Name:_____ DOB:_____ SS#:_____

Address:_____

Home Phone#_____ Work:_____ Cell:_____

Place of Employment:_____ Number of Years:_____

Referred to By:_____

Any Previous Psychiatric Treatment(Please give Doctor's Name)_____

List Any Medication Your Are Presently Taking:_____

_____

List Any Known Allergies:_____

List Any Medical/Surgical Problems and the Name of Attending Doctor_____

_____

If Patient Is A Minor, Please Fill Out Below

Mother's Name:_____ Phone#:_____

Father's Name:_____ Phone#:_____

In Case Of An Emergency, List A Friend Or Relative To Notify

Name/Relationship:_____ Phone#:_____

Name/Relationship:_____ Phone#:_____

Insurance Information

Name of Insurance:_____
Policy Holder:_____
Relationship to Patient:_____
Policy Holder DOB:_____
Policy Holder SS#:_____
Policy Number:_____

Name of Insurance:_____
Policy Holder:_____
Relationship to Patient:_____
Policy Holder DOB:_____
Policy Holder SS#:_____
Policy Number:_____

Patient Name:_____ DOB: _____

Consent to Treatment

I hereby consent to examination and treatment by David S. Deuser M.D. & Associates. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that such person is the parent, legal guardian, or person other wise allowed, by law, to consent to the examination and treatment of the patient, and by their signature hereby so consent.

_____

Patient Signature

_____

(If a Minor) Parent or Legal Guardian

_____

Date

David S. Deuser MD and Associates now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from David S. Deuser and Associates via email or text messaging.. David S. Deuser and Associates does not share the manes, e-mail addresses, and /or telephone number of patients with any company, or with any other patient.

YES or NO I would like to receive e-mail and/or text messaging confirmations.

Please print all information neatly and legibly.

E-Mail Address_____

Cell Phone_____

I hereby give David S. Deuser and Associates permission to send messages to me via e-mail and/or text messaging as a means of communication as indicated in my selection above.

Patient Name:_____ DOB: _____

Client Information & Office Policy Statement

To Our Patient:
We Think it is important that you know some things about David S. Deuser, M.D. & Associates . We are, first and foremost, health care professionals and our primary interest is in the care and treatment of our patients. Please read the following information regarding our services and expectations. If at any time you have any problem with appointment times, staff members, payment arrangements, or any other problems or requests, please let us know.

Confidentiality
We are not allowed to release any information concerning your treatment unless you waive your right to confidentiality by signing a "release of Information" form. We are required, however, to release client information in certain cases, such as child abuse, when there is a potential of serous harm to one's self or others, and when requested by insurance carriers. We must also comply with court orders should records be subpoenaed. Confidentiality is our primary concern and we want our clients to know that, without your consent or unless otherwise required by law , what you talk about in treatment is held in strict confidence.

Fees:
Payment is due when services are rendered. David S. Deuser, M.D. & Associates will file for direct payment from my insurance company. However, I understand I am financially responsible for all charges for services rendered to me my David S. Deuser, M.D. & Associates and I guarantee payment for these services.

_____ _____
Patient/Parent/Guardian Signature Date

Medication Refills:
A certain standard of care must be followed when a patient is on medication. If appointments for medication follow-ups are missed, one script may be given with a fee of $30 to refill. A new appointment must be scheduled and kept or no medications or prescriptions will be give until patient is seen by the doctor. In the event that a prescription is lost or stolen, we will ask for a police report before refilling a prescription. A police report is for your own protection in that anyone who comes in possession of your medicine could claim that they were given it or sold it by you. If lost or misplaced medications become an issue, we do reserve the right to refer yo to another physician.

Insurance:
If you maintain health insurance, part of your therapy expenses may be covered. We will make our best effort to verify your insurance coverage regarding the services covered and the practitioner's credentials necessary to provide quality care. However, you will ultimately be responsible for the portion of your bill that insurance does not pay.

Billing Statements:
We encourage all payments at the time of service, but in the event of a balance, statements are mailed every thirty (30) days even though an insurance claim may have been filed on your behalf. If you have a problem paying the balance of your account, please discuss a payment plan with the Billing Manager.

Patient Name:_____ DOB: _____

Cancellations and Missed Appointment:
If you cannot keep your appointment, please cancel or reschedule at least twenty-four (24) hours before the appointment time. The time we set aside for you is for you alone. If you must occasionally miss an appointment, please let us know early enough to allow another patient to utilize the time. If you do not give a 24-hour notice, a $50 cancellation fee will be charged. Cancellation fees are not covered by insurance. It will be the patient's (parent's/guardian's should the patient be under 18 years of age) responsibility and must be paid prior to another appointment being scheduled. If you have missed or canceled two (2) appointments with less than 24 hours notice, we reserve the right to cancel any further appointments that may be scheduled.

We believe that responsible therapy involves appropriate termination when a patient is ready to end regular sessions. The decision to end therapy should be a joint decision between you and your clinician,. If you must end therapy prematurely, we ask that you tell your clinician at least one (1) session before the last session so that we can plan a termination session. We encourage you to talk it over with your clinician and make a decision that is best for you.

Prescription Refills:
Please be sure you have all prescriptions renewed while you are in the office. Prescriptions will not be refilled if you do not come to your appointment. If there is an emergency preventing you from making your appointment and/or you have lost your prescription and you find it necessary to call for a refill, please give our office 48 hours notice to call your pharmacy. When you call, please have the name and telephone number of your pharmacy ready. When a phone refill is approved By the provider, the office staff will setup the next available appointment any refill approved will last until that appointment. The charge for refills is $30. This charge is directly billed to the patient and not chargeable to insurance.

Phone Refills will not be done at night or over the weekend. Please call during normal office hours so that medical providers have access to your chart.

Medications are to be taken only by the person for whom it is prescribed. Medication for children and adolescents are to be administered daily by a parent or guardian and they should not have unsecured access to medications and most pharmaceutical items.

Medical Records and Paperwork:
Due to the number of request to send our medical records and fill out paperwork, we charge a $25 fee per each request. This charge will need to be paid at the time the Release of Information form is signed. This charge is billed directly to you, the patient. You may at any time try to seek reimbursement from the party that is requesting you records. Ultimately you will be held liable for the charge. Legally the records are the property of David S. Deuser, M.D. & Associates and ultimately it is their decision on how the records are to be released.

Psychological Testing:
Your therapist or physician may recommend psychological testing to assist in understanding your condition. This is often a cost-effective way of establishing a treatment plan. Your therapist will discuss the type, length and purpose of any psychological testing recommended. The psychologist requested to perform the testing can give you an estimated cost.

Patient Name:_____ DOB: _____

Follow Up:
We may seek information periodically about our services. To gather this information, we sometimes send out brief questionnaires to patients. We also prefer to call/text to confirm appointments the day before. Do we have your permission to contact you by telephone, text, or mail? ( )yes ( ) No

What telephone number should we call/text to gather information as well as to remind you of your appointment?

Home:_____ Work:_____

Cell:_____ Other:_____

We are committed to quality patient care. If you have any concerns or questions about these policies, please talk with your physician, therapist, office manager or clinical administrator.

By signing below, you acknowledge that you have read the above office policies, understand them fully, and agree to enter therapy under all of these conditions.

_____ _____
Patient Signature Date

_____ _____
(If Minor) Legal Guardian Date

Assignment of Benefits:
I authorize my insurance carrier(s), as noted on the preceding page of the "Patient Information Packet", to pay directly to David S. Deuser, M.D. & Associates the medical benefits otherwise payable to me for services as described on any and all claims attached hereto. I further accept responsibility for any allowable charges above what my insurance carrier(s) pay.

Patient Name:_____ DOB: _____

Medicaid Coverage:
The following information if for patients whom have secondary or tertiary coverage through the Georgia Medicaid program.

Some of the procedure codes billed to commercial carriers for the care provided are not payable by Medicaid. If you are receiving a care that will not be covered by Medicaid, you will be respons ible for any deductible or co-payment required by your commercial carrier.

The billing office will be happy to discuss this with you further before your appointment.

_____
Patient Signature

_____
(If a Minor) Parent of Legal Guardian

_____
Date

Patient Name:_____ DOB: _____

Acknowledgment of Receipt of This Notice of Health Information Practices:
I have been presented with a copy of David S. Deuser, M.D. & Associates Notice of Health Information Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be filed in my medical record, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

_____ _____
Patient/Parent/Guardian Signature Date

If not signed by patient, please indicate relationship to patient

_____ _____
Relationship Witnessed By

Internal Use Only:
If patient refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on :_____ By:_____

In order for our office to speak to anyone regarding the patient, a Release of Information form from our office must be signed and notarized.

Patient Name:_____ DOB: _____

Information Authorization:

I hereby give permission to David S. Deuser, M.D. & Associates to release information concerning my psychiatric evaluation ad consultation, diagnosis, personal history, treatment and examination for insurance purposes, to my referring physician, or to another physician for referral of my case and to furnish further reports pertaining hereto. I also hereby authorize the release of medical information to any insurance company with whom I have medical or surgical benefits for the purpose of filing a medical claim. Finally, I agree that David S. Deuser, M.D. & Associate's it's employees, or any principal, partner or independent contractor of David S. Deuser, M.D. & Associates shall not be held liable in any ,manner for furnishing or having furnished such information.

_____

Patient Signature

_____

(If Minor) Parent of Legal Guardian

_____

Date

Patient Name:_____ DOB: _____

Benzodiazepine/Psychostimulant Utilization Agreement

If you are an adult prescribed a Benzodiazepine and/or Psychostimulant by David S. Deuser M.D. & Associates:

1. Medical Staff will **NOT** address requests for dosage increases over the phone. It will need to be addressed at your next appointment. You may try to make an earlier appointment to be seen and discuss your concerns if desired.
2. If you have been taking the medication at a dose of frequency greater than prescribed, the Medical Staff will **NOT** authorize early refills or additional refills prior to your return appointment time frame. Misuse of any medications may be detrimental to your health.
3. Medical Staff **MAY** consider authorization of an early refill for stolen or damaged medication. This will require a police report if medicine was stolen. This will be considered for one occasion and on a case-by-case basis.
4. A quantitative urine drug and alcohol screen **WILL BE** performed at the initial visit for adults and teenagers receiving these types of medication. This is to monitor for misuse including excessive concentration, absence or low concentration of a prescribed medicine; duplication by other prescribers; medication interactions; and illicit drug use.
5. Additional, interim screens may be ordered at the discretion of the clinician.
6. In compliance with Georgia Law, The Prescription Drug Monitoring System reports will be run at each visit or for other pressing needs. These reports provide information about all controlled substance prescriptions across multiple states.
7. If a person has positive results for misuse, duplication or illicit drugs including Cocaine, Methylphenidate, Methamphetamines, Barbiturates, Opiates and others the Medical Staff will **DENY** Benzodiaepine/Psychostimulant prescriptions. A positive result may prompt a recommendation for referral for Alcohol and Drug Assessment and may terminate your ability to be a patient at David S. Deuser M.D. & Associates.
8. You may refuse the drug screen; **HOWEVER**, in such case the medical staff cannot prescribe any Benzodiazepine and/or Psychostimulant.

I, _____ (printed name), have reviewed, understand and **AGREE WITH /REFUSE** (must circle one) the above agreement.

_____ (Signature) ____/____/____(Date)

_____(Signature) ____/____/____(Date)